

Health Record Form

Association Free Lutheran Bible School
3134 East Medicine Lake Boulevard
Plymouth, MN 55441-3008

Medical History (to be filled out by applicant)

Name _____ Address _____ Sex: ___ M ___ F

Insurance Company _____ Policy Number _____

Have you had the following: Yes No Yes No Yes No

Scarlet Fever			Palpitations (Heart)			Shortness of Breath		
Measles			High or Low Blood Pressure			Allergy		
German Measles			Back Problems			Penicillin		
Mumps			Tumor, Cancer, Cyst			Sulfonamides		
Chicken Pox			Jaundice			Serum		
Malaria			Joint Disease/Injury			Foods (which ones)		
Gum or Tooth Trouble			Rheumatic Fever/Heart Murmur			Other		
Sinusitis			Trick Knee, Shoulder, etc.			Gall Bladder Trouble/Stones		
Eye Trouble			Stomach/Intestinal Trouble			Recurrent Diarrhea		
Ear,Nose,Throat Trouble			Insomnia			Rupture, Hernia		
Surgery			Frequent Anxiety			Recent Gain/Loss of Weight		
Appendectomy			Worry or Nervousness			Dizziness, Fainting		
Tonsillectomy			Recurrent Headache/Migraine			Weakness, Paralysis		
Hernia Repair			Recurrent Colds			Venereal Disease		
Other			Hay Fever, Asthma			Frequent Urination		
Pain/Pressure in Chest			Head Injury/Unconsciousness			Females Only: Severe Cramps		
Chronic Cough			Tuberculosis			Irregular Periods		
						Excessive Flow		

Do you feel that any of the above conditions might hinder you in your Bible School classes or adjustment? _____
If so, please explain. _____

To the Examining Physician: Please review the student's history and complete this form.

Your cooperation is appreciated.

Height: _____ ft _____ in Weight: _____ lbs Temperature: _____ Pulse: _____

Blood Pressure: _____ Respiration: _____ Corrected Vision: right 20/_____ left 20/_____

Urinalysis: Sugar _____ Micro _____ Albumin _____ HGB _____

IMMUNIZATION: Completed Date of Last Injection TB Skin Test: Positive _____ Negative _____ Date _____

Tetanus Yes No _____ Chest X-Ray (if TB test is positive) _____ Date _____

Polio Yes No _____

Measles Yes No _____

German Measles Yes No _____

Does the applicant have any history of the following:

1. Tuberculosis Yes No Comments: _____

2. Diabetes _____

 Does the student take insulin? _____

	Yes	No	Comments:
3. Epilepsy.....	_____	_____	_____
Is the student on medication?	_____	_____	_____
4. Heart Condition.....	_____	_____	_____
5. Infectious Hepatitis	_____	_____	_____
6. Rheumatic Fever.....	_____	_____	_____
7. Hernia.....	_____	_____	_____
8. Allergies	_____	_____	_____
9. Infectious Mononucleosis	_____	_____	_____
10. Mental Disorders.....	_____	_____	_____
11. Scoliosis	_____	_____	_____
12. Other	_____	_____	_____

Abnormalities Present:

1. Head	_____	_____	_____
2. Neck.....	_____	_____	_____
3. Throat.....	_____	_____	_____
4. Lungs	_____	_____	_____
5. G.I.	_____	_____	_____
6. Other	_____	_____	_____

Other serious illness or surgeries? _____

Any present treatments or medications? _____

Special diet? _____

If applicant has to earn money while at school, is he/she physically able to undertake such work in addition to studies? _____

I certify that, to the best of my knowledge, the above named student IS / IS NOT physically capable to pursue a full-time curriculum without detriment to his/her health.

Signature of Physician _____ Date _____

Physician, Please Print Name Here: _____ Clinic Name: _____

Please mail completed form to the following address: Association Free Lutheran Bible School
 3134 East Medicine Lake Boulevard
 Plymouth, MN 55441-3008