Word of Life
Africa Bible Institute

HEALTH RECORD

Year Entered _____

STUDENT INFORMATION

Name: _____ DOB: ____/____/____ ID No: _____

Address: _____ Gender: ☐ Male ☐ Female Height _____ Weight _____

EMERGENCY CONTACT INFORMATION

Circle One: Parent Guardian Spouse Name: _____ Cell: _____

IMMUNIZATION RECORD

Immunization required for enrollment: must be completed and signed by a health care professional or attach official copies with a stamp or letterhead from your health care provider. All documents must be in the English language.

Immunization Record: MMR and current tetanus are required. ***If you have not had the Hepatitis B or Meningitis vaccinations, you must complete the waiver below before signing the health form and submitting it.***

	MMR	Most recent Tetanus (Td/Tdap)	Meningitis	Hepatitis B
Dose 1				
Dose 2				
Dose 3				

Mantoux Tuberculosis Skin Test. TB skin test (and x-ray if test is positive) must be within 1 year of admission.

Date of last TB skin test: _____/_____/_____ Results: _____mm induration. If positive provide chest x-ray documentation.

Have you ever been treated for tuberculosis? ☐ Yes ☐ No Have you received the BCG vaccine? ☐ Yes ☐ No

☐ Yellow Fever *(must have the yellow book)*

Health Care Provider: Complete the above information, sign and date

_____ ____/____/____

PRINT NAME AND TITLE SIGNATURE DATE: MM DD YYYY

INSURANCE INFORMATION

Do you have health insurance? ☐ Yes ☐ No Name of provider: _____

ATTACH COPY OF INSURANCE CARDS

RESPONSE AND CONSENT

Check one statement regarding Meningococcal Meningitis if you have not had the vaccine:

☐ I have *(my child has)* read, or have had explained to me information regarding meningococcal meningitis disease. We will obtain immunization against meningococcal meningitis within 30 days of the first day of class from my private health care provider or Word of Life Bible Institute health center will facilitate the immunization via a local physician's office.

☐ I have *(my child has)* read, or have had explained to me information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I *(my child)* will <u>not</u> obtain immunization against meningococcal meningitis disease.

Check one statement regarding Hepatitis B if you have not had the vaccine:

☐ I have *(my child has)* read, or have had explained to me information regarding Hepatitis B disease. We will obtain immunization against Hepatitis B within 30 days of the first day of class from my private health care provider or Word of Life Bible Institute health center will facilitate the immunization via a local physician's office.

☐ I have *(my child has)* read, or have had explained to me information regarding Hepatitis B disease. I understand the risks of not receiving the vaccine. I have decided that I *(my child)* will <u>not</u> obtain immunization against Hepatitis B disease.

Read and sign:

I hereby authorize the Health Care Staff at Word of Life Fellowship, Inc. to exercise on my behalf, all rights and duties with reference to consenting to all appropriate medical care and treatment. To be done under the medical auspices, consultation and direction of a local practicing physician and/or surgeon. Including any medicines and hospitalization by any hospital, staff surgeon, physician, radiologist or dentist, which they may deem necessary for my care, or son or daughter if under age of 18.

Name: _____ Signature _____ Date: _____

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CONFIDENTIAL PERSONAL HEALTH HISTORY REPORT

Allergies – Please specify to what and treatment as needed

Medication: _____

Food / Environmental: _____

Medications – please list any current medications and reason for each: _____

_____

Recent serious injuries, illness, surgical procedures – please explain what and when:

_____

_____

Psychiatric history – please explain any therapies by a counselor, psychiatrist, psychologist: _____

_____

Illegal drug use – please explain when and what you used:

_____

_____

Please check the following that apply according to your health history. Indicate at what age this occurred and if it is a current problem.

Cardiopulmonary	Yes	Age	Current Problem
Asthma		___	
Heart Disease		___	
Heart murmur		___	
High Blood Pressure		___	
Pneumonia		___	
Other _____		___	

Metabolic	Yes	Age	Current Problem
Diabetes		___	
Insulin dependent		___	
Thyroid problems		___	
Other ___		___	

Musculoskeletal	Yes	Age	Current Problem
Arthritis		___	
Back problems		___	
Fractures		___	
Hernia		___	
Polio		___	
Other _____		___	

Gastrointestinal	Yes	Age	Current Problem
Irritable Bowel		___	

Infectious disease	Yes	Age	Current Problem
Chicken Pox		___	
Measles		___	
Rubella *(German measles)*		___	
Mumps		___	
Meningitis		___	
Mono		___	
Malaria		___	
Rheumatic fever		___	
Scarlet fever		___	
Tuberculosis		___	
Hepatitis		___	
Whooping cough		___	
HIV positive		___	
Other _____		___	

Neuropsychiatric	Yes	Age	Current Problem
Depression		___	
Epilepsy		___	
Head injury		___	
Severe headache		___	
Mental disorder		___	
Drug overdose		___	
Suicidal acts		___	

Ulcer		___	
Appendicitis		___	

Other ___		___	

Current Physical Limitations: _____

_____

_____

Mailing Instructions:

1. Fill out the form completely following all instructions carefully. Make sure to sign and date front of the form in the response and consent section.
2. Attach a copy of all insurance cards (medical, dental, vision, etc…).

MAIL DIRECTLY TO:

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- Email: admissions@woluganda.org