SOUTHLAND BIBLE INSTITUTE
ASHLAND, KENTUCKY
STUDENT HEALTH FORM

TO THE STUDENT: A health history form is required of all students of Southland Bible Institute as a means of ensuring the safety and well-being of the student body. This health information is confidential. However, the information may, at the discretion of the school administrators, be shared with and/or made available to members of the faculty or staff as necessary. Please read the form carefully; answer all questions on **both sides** of the form.

<table>
<tr><td colspan="3">Name_____
(last) (first) (middle initial)
Current Address:_____
_____</td><td colspan="3">Return To:
Southland Bible Institute
238 W Southland Dr
Ashland KY 41102</td></tr>
<tr><td>I.</td><td>Social Security #</td><td>Birth Date:</td><td colspan="3">Expected Entrance Year 20_____
Semester:
Fall: { }
Spring: { }</td></tr>
<tr><td>II.</td><td colspan="2">Name of person to be notified in case of emergency:
_____ Address:_____
_____</td><td>Relationship</td><td colspan="2">Phone Number:</td></tr>
<tr><td>III.</td><td colspan="5">Physician's Name:_____
Office Address: _____
Phone #:_____</td></tr>
<tr><td rowspan="4">IV.</td><td colspan="5">Are you covered by hospitalization insurance? Yes { } No { }
If yes, please complete this section.</td></tr>
<tr><td colspan="5">Name and address of Insurance Company or Agency: _____
Policy Number: _____ _____
_____</td></tr>
<tr><td colspan="3">Name of Policyholder:</td><td colspan="2">Relationship to Student:</td></tr>
<tr><td colspan="5">Address of Policyholder:_____
_____
_____</td></tr>
<tr><td colspan="6">DO NOT WRITE IN THIS SPACE

Reviewed by:_____

Comments:_____

_____</td></tr>
</table>

All applicants meeting the appropriate academic and spiritual requirements shall be considered equally for admission to Southland Bible Institute regardless of race, color, sex, marital status, national origin, age or handicap.

V. Instructions
1. Answer all items
2. Mark “X” in the “YES” column if you have a history of any of the items listed in the given question; otherwise, mark “X” in the “NO’ column.
3. For any “YES” answers:
   i. Circle the appropriate item(s) within the question.
   ii. In the “REMARKS” column, indicate the number of the question and give a brief statement of the problem or condition
4. Sign and date.

NO		HAVE YOU A HISTORY OF ANY OF THE FOLLOWING?	YES	REMARKS
	1.	Hospitalizations		
	2.	Continuing use of prescribed medications		
	3.	Drug allergies or other allergies		
	4.	Rheumatic fever, heart murmur, cyanosis, abnormal or irregular heart rate or rhythm, or recurrent chest pain		
	5.	Shortness of breath at rest or after mild exertion, heart failure, swelling of the hands or feet. High blood pressure		
	6.	Excessive or prolonged cough or sputum production, coughing up blood, or chest pain on breathing deeply		
	7.	Pneumonia, bronchitis, tuberculosis, sinusitis, asthma, or frequent sore throats or ear infections.		
	8.	Vomiting of blood, blood with a bowel movement, black stools, jaundice, or recurrent episodes of nausea, vomiting, diarrhea, or persistent abdominal pain		
	9.	Disorder of the liver, gall bladder, stomach or intestine		
	10.	Diabetes; under-active or over-active thyroid gland; diseases of any endocrine gland		
	11.	Double vision, fainting spells, seizures or recurrent severe headaches		
	12.	Numbness, paralysis, tremor, persistent or progressive weakness of body parts		
	13.	Urinary tract infection (bladder of kidney infection)		
	14.	Blood, pus, protein, sugar, or stones in the urine		
	15.	(Males only) Prostate infection		
	16.	(Females only) Abnormal or irregular menstrual periods; disorder of the ovary; recurrent vaginal infection		
	17.	Counseling or treatment for emotional problems in past five years		
	18.	Any physical handicap which may cause difficulty in performanceof normal activities? i.e. blindness, hearing loss, difficulty in walking, speech defects, missing limbs, paralysis, etc.		
	19.	Abnormal chest x-ray (if yes, give date, place of x-ray, and diagnosis)		
	20.	a. Positive skin test for tuberculosis		
		b. Treatment for a positive test for tuberculosis		
	21.	FAMILY HISTORY: tuberculosis, cancer, diabetes, high blood pressure, heart condition, any inherited disease or unusual illness		
	22.	Would you like to see a staff person to discuss any of the items above or others not mentioned?		

VI. Immunizations within the last 10 years:

Tetanus	No_____	Yes_____
Diphtheria	No_____	Yes_____
Polio Myelitis	No_____	Yes_____
Hepatitis	No_____	Yes_____

STUDENT SIGNATURE:_____DATE_____