



YELLOWSTONE BAPTIST COLLEGE

STUDENT HEALTH RECORD

Both sides of this form must be completely filled out and returned to the Admission Office.

TRANSFER STUDENTS: A transcript of your health record from your former college will be accepted.

Social Security # _____ Date of Birth ____/____/____ Sex: ____ Male ____ Female

Date of Planned Enrollment at YBC: Fall 20____ January Term 20____ Spring 20____ Summer 20____

Name _____
Last First Middle

Home Address _____
Street City State Zip

MEDICAL HISTORY

History of Diseases (please check and give approximate age)

- | | | | | |
|--|---|--|--|------------------------------------|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Measles | <input type="checkbox"/> Typhoid |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> German Measles | <input type="checkbox"/> Malaria | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Smallpox | <input type="checkbox"/> Gastric Ulcer | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Poliomyelitis | |

HISTORY OF OPERATIONS AND INJURIES

Specify operations, giving nature and dates: _____

PERSONAL HISTORY

Do you have a physical restriction? Yes No

If yes, explain: _____

Have you ever been under treatment for a mental or emotional illness or depression? Yes No

If yes, explain: _____

Have you ever been treated for drug or alcohol abuse? Yes No

Type of treatment for above condition(s): _____

List of medication that you are presently taking: _____

List of any known drug allergies: _____

Has any blood relative had the following diseases? State relationship to you.

- Tuberculosis Asthma Heart Disease Diabetes Hemophilia

Have you ever had the following?

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Fainting or dizziness | <input type="checkbox"/> Persistent cough | <input type="checkbox"/> Convulsions |
| <input type="checkbox"/> Frequent/severe headaches | <input type="checkbox"/> Back trouble | <input type="checkbox"/> Hay fever |
| <input type="checkbox"/> Swollen or painful joints | <input type="checkbox"/> Stomach/intestinal trouble | |

I certify that the above history is complete to the best of my knowledge.

Signature of Applicant: _____ Date: _____

(over)

