Personal Health Report

Elim Bible Institute and College

New York State requires this form be completed as part of the enrollment process. Please type or print your full legal name using blue or black ink.

Last Name: ____________________________________ First Name: ___________________________________ M.I.: _______

Date of Birth:_____/_____/_____ Gender: ☐ Male ☐ Female Social Security #__________________________

Home Address____ Country:____________________________

City:____ State:_____________________ Zip Code:______________________

Home Phone:____ Cell Phone:____

Certificate of Immunization

Necessary for students born on or after January 1, 1957,
who are enrolling for 6 or more credit hours or are living in the dormitories on campus.

Physician or Health Care Provider must complete this section and sign below.

Measles: Two doses of live Measles vaccine (given 1968 or after). First dose on or after 12 mo. of age, second dose on or after 15 mo. of age.

Date of first dose: _____/_____/_____ Check box if vaccine was MMR☐

Date of second dose: _____/_____/_____ Check box if vaccine was MMR ☐

- Or physician diagnosis of disease (include date of disease):___________________________________ _____/_____/_____
- Or serological evidence of immunity. (Notation by Physician or certified medical lab report stating, "Antibodies are positive and demonstrate a level of immunity.") Include a copy of lab report.

Mumps: One dose of live mumps vaccine received on or after first birthday. Date of dose: _____/_____/_____

- Or physician diagnosis of disease (include date of disease): ____________________________________ _____/_____/_____
- Or serological evidence of immunity. (Notation by Physician or certified medical lab report stating, "Antibodies are positive and demonstrate a level of immunity.") Include a copy of lab report.

Rubella: One dose of live rubella vaccine received on or after first birthday. Date of dose: _____/_____/_____

- Or physician diagnosis of disease (include date of disease): ____________________________________ _____/_____/_____
- Or serological evidence of immunity. (Notation by Physician or certified medical lab report stating, "Antibodies are positive and demonstrate a level of immunity.") Include a copy of lab report.

The following immunizations are highly recommended. If the student has received *any* of these, please fill in below:

- **Tetanus-Diptheria:** Date of Dose: _____/_____/_____
- **PPD (Mantoux):** Result:_________________ Date of reading: _____/_____/_____ PPD required for all students living outside of North America.
- **Hepatitis B:** Date of first dose: ____/____/____ Date of second dose: ____/____/____ Date of third dose: ____/____/____
- **Polio:** Primary series completion date:____/____/____ Booster date: ____/____/____
- **Varicella (Chicken Pox):** Disease date: ____/____/____ Date of Vaccine: ____/____/____
- **Meningococcal:** Date of Vaccine: ____/____/____ The CDC strongly recommends meningitis vaccine for all dorm students.

Health Care Provider Signature:____MD, DO, PA, NP

Health Care Provider Address:____

City: ____ State: ______________________ Zip Code:___________________

Phone: ______________________ ID Number:________________________________ Date: _____/_____/_____

Return form to address on the following page. WARNING: Faxes that are not readable or complete *cannot* be used.

Health Screen

• Do you have allergies to medication? Please list them:______________________________

• Are you allergic to anything? Please list them:______________________________

• Are you taking any medications now? Please list them:______________________________

Circle anything that applies to you now or in the past and give an explanation for each item you circle.

• Eye problems, glaucoma, stigmatism, blindness, other:______________________________

• Ear problems, infections, tubes, hearing loss, other:______________________________

• Nose problems, sinusitis, nosebleeds, other:______________________________

• Throat problems, recurrent strep infection, other:______________________________

• Lung problems, asthma, emphysema, bronchitis, pneumonia, pleurisy, other:______________________________

• Heart problems, murmur, hypertension, heart attack, angina, heart failure, arrhythmia, other: ______________________________

• Stomach problems, ulcer, gastritis, reflux disease, other:______________________________

• Intestinal problems, chronic diarrhea, chronic constipation, inflammatory bowel disease, diverticulitis, bleeding from the bowel, other: ______________________________

• Liver or gall bladder problems, hepatitis, gall stones, other:______________________________

• Kidney or bladder problems, infections, stones, bleeding, other: ______________________________

• Neurological problems, migraines, tension headaches, seizures, other:______________________________

• Anemia, bleeding disorder, cancer, other: ______________________________

• Diabetes, thyroid problem, other:______________________________

• **Females:** breast lump, irregular PAP smear, painful menstruation, ovarian cysts, pregnant (how many times?):______________________________

• Infectious diseases, positive HIV test, AIDS, mononucleosis, Lyme Disease, other:______________________________

• Physical disability: ______________________________

• Drug or alcohol abuse treatment: ______________________________

• Eating disorder:______________________________

• Depression, suicide attempt, anxiety disorder, bipolar disorder, schizophrenia, or other psychiatric problem: ______________________________

• I have used medication for depression or another psychiatric problem: ________________ What medicine: ________________

• When was the last time you took it:______________________________

• I have been hospitalized for depression or a psychiatric problem:________________When?________________

• List any operations you have had and give the dates of them:______________________________

• List any other medical problems that you have had or any problems you are currently experiencing:______________________________

Consent for Treatment:

I authorize medical treatment for: ☐ Myself (if applicant is 18 years of age or over) ☐ My child ☐ My dependent
in the event that such care is deemed necessary by a licensed medical professional. I authorize a hospital to provide life-saving care or surgery in the event of a life-threatening emergency.

Print applicant's name: ______________________________

Signature of applicant (or parent/guardian if applicant is under 18 years of age):______________________________

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