Medical Record

ADMISSIONS OFFICE

FAIRHAVEN BAPTIST COLLEGE

86 East Oak Hill Road

Chesterton, Indiana 46304

Name _____ Age _____ Sex _____

Marital Status _____ Occupation _____

(single, married, widowed, divorced)

HISTORY

PLEASE CHECK IF YOU HAVE HAD:

- ❑ Diabetes
- ❑ Epilepsy
- ❑ Rheumatic Fever
- ❑ Arthritis
- ❑ Scarlet Fever
- ❑ Frequent Head Colds
- ❑ Frequent Tonsillitis
- ❑ Frequent Chest Colds
- ❑ Diphtheria
- ❑ Fainting Attacks
- ❑ Pleurisy
- ❑ Allergies (list below)
- ❑ Pneumonia
- ❑ Eye Problems
- ❑ Malaria
- ❑ Frequent Headaches
- ❑ Typhoid Fever
- ❑ Asthma
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Tuberculosis
- ❑ Thyroid Disease
- ❑ Anemia
- ❑ Mumps
- ❑ Sinus Disease
- ❑ Weight Loss of Over 10 Pounds During Last Year
- ❑ Chicken Pox
- ❑ Whooping Cough
- ❑ Venereal Disease
- ❑ Kidney or Bladder Disease
- ❑ Jaundice
- ❑ Heart Disease
- ❑ Liver Disease
- ❑ Mental Disease
- ❑ Military Service Overseas

History of Injuries: If any, give short account. If none, indicate "none." _____

_____

History of Operations: If any, when? What? If none, indicate "none." _____

_____

Allergies: _____

IMMUNIZATIONS

	Date	Date	Date	Date
Diphtheria (four dates required)	_____	_____	_____	_____
Tetanus (four dates required)	_____	_____	_____	_____
Pertussis (four dates required)	_____	_____	_____	_____
Poliomyelitis (three dates required)	_____	_____	_____	_____
Measles (required)	_____	_____	_____	_____
Rubella (required)	_____	_____	_____	_____
Mumps	_____	_____	_____	_____
Tine Test/T.B. x-ray (one date required)	_____	_____	_____	_____

FAMILY HISTORY
(Parents, grandparents, brothers and sisters)

- ❑ Cancer
- ❑ Tuberculosis
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Leukemia
- ❑ Kidney Disease
- ❑ Diabetes
- ❑ Allergy
- ❑ Venereal Disease
- ❑ Mental Disease
- ❑ Brain Tumors
- ❑ Arthritis
- ❑ Epilepsy

(over)

TO BE COMPLETED BY PHYSICIAN

Name _____

Date _____ Age _____ Sex _____ Race _____

Marital Status _____
(single, married, widowed, divorced)

Height _____ Weight _____ Blood Pressure _____ Temp. _____ Pulse _____

Vision without glasses: Right _____/_____ Left _____/_____
Vision with glasses: Right _____/_____ Left _____/_____
E. E. N. T.
Heart
Lungs
Abdomen
Extremities
Reflexes
Urine: Sugar _____ Albumin _____ Microscopic _____

Does this person appear physically capable of enrolling in school? ❑ Yes ❑ No

List any limitations:

Physician _____ **Address** _____
(street) (city) (state)

FAIRHAVEN BAPTIST COLLEGE
EMERGENCY PERMIT

STUDENT'S NAME _____

In the event that an emergency should arise, I hereby give Fairhaven Baptist College permission to authorize emergency anesthesia, surgery, and/or procedures deemed necessary.

(This permit is required of every student. For those students under 18 years of age, the person legally responsible must sign for him.)

DATE _____

_____
SIGNATURE

_____
NAME (Please print)

_____
ADDRESS

_____
CITY STATE ZIP

_____
AREA CODE PHONE NUMBER

_____
AREA CODE EMERGENCY NUMBER