INDIANA BIBLE COLLEGE

Confidential Health History

APPLICANT INFORMATION

Full Name _____

Permanent Address _____

City _____ State _____ ZIP _____

Home Phone ____–____–_____ **Cell Phone** ____–____–_____ **E-mail** _____

Date of Birth ____ | ____ | _____ **S.S. #** _____–_____–_____ **Male** ☐ **Female** ☐

Emergency Contact

Name _____ Relationship _____

Address _____

Home Phone _____–_____–_____ Work/Cell Phone _____–_____–_____

Primary Care Physician

Name _____

Office Address _____

Office Phone _____–_____–_____ Fax _____–_____–_____

HEALTH HISTORY

Do you have any allergies? Yes ☐ No ☐

If yes, please explain the type of allergies and any medications taken or prescribed as treatment for them.

_____

_____

Do you have any chronic illnesses, communicable diseases, or other major health problems?

Yes ☐ No ☐ If yes, please explain.

_____

_____

_____

Do you have any physical, mental or emotional condition or disability that would restrict your ability to participate in regular day-to-day activities or classes at IBC?

Yes ☐ No ☐ If yes, please explain.

_____

_____

_____

List any prescription medications that you take on a regular basis.

_____

_____

_____

_____

Do you have any health issues or physical or mental conditions that require special attention or continuing treatment? Yes ☐ No ☐ If yes, please explain.

_____

_____

_____

_____

Do you drink alcohol or smoke or use tobacco of any kind? Yes ☐ No ☐

Do you use illegal drugs or use prescription drugs or over-the-counter medication in an illegal manner? Yes ☐ No ☐

INSURANCE INFORMATION

Are you covered by health insurance? Yes ☐ No ☐

Name of Insurance Company _____

Address _____

Phone _____–_____–_____ Policy # _____ Group # _____

Name on Insurance Card _____

CERTIFICATION AND SIGNATURE

I hereby certify that the information contained in this Confidential Health Form is true and accurate to the best of my knowledge. Further, I agree to promptly notify IBC of any changes to the information contained in this form. Finally, I understand and agree that IBC does not provide health insurance coverage for me and that if I desire health insurance coverage, I am responsible for obtaining and for the cost of any such insurance.

Applicant's Signature _____ Date ____ | ____ | _____