HOBE SOUND BIBLE COLLEGE
HEALTH FORM

Hobe Sound Bible College, P.O. Box 1065, Hobe Sound, FL 33475
Phone (772) 546-5534, Fax (772) 545-1403

HSBC provides first-aid care for minor illnesses and injuries, but does not offer hospital service. Students who have prolonged illness such as epilepsy, asthma, rheumatic fever, diabetes etc. should have their private physician make a direct referral to a physician in the Martin County area.

Name____Date of Birth_________________________

Address____

Name\Address of Parent or Guardian who should be notified in case of illness or emergency

____

Home Phone (_____)_______________________ Work Phone (_____)_________________________________

*

Medical History:

AIDS (answer confidential)	☐	Ear Trouble	☐	Peptic Ulcer	☐
Allergies	☐	Epilepsy	☐	Pneumonia	☐
ARC(Aids related complex)	☐	Fainting Spells	☐	Rheumatic Fever	☐
Arthritis	☐	Heart Trouble	☐	Respiratory Illness	☐
Asthma	☐	Hepatitis	☐	Skin Disorder	☐
Bleeding Tendencies	☐	HIV	☐	Tonsillitis	☐
Bronchitis	☐	Malaria	☐	Tuberculosis	☐
Chicken Pox	☐	Measles	☐	Typhoid Fever	☐
Diabetes	☐	Mumps	☐	Venereal Disease	☐

Do you:

Wear glasses\contacts? ☐ Yes ☐ No Have any allergies? ☐ Yes ☐ No ☐ Food ☐ Medicine

☐ Other Currently take any medications? ☐ Yes ☐ No If so, what?___________________________

Have a diagnosed learning disability? ☐ Yes ☐ No If yes, explain

____

Date of last tetanus shot ________________________

I certify that, to the best of my knowledge, the answers are correct and that I have read the policy statement of Hobe Sound Bible College at the top of this page. I further certify that I have no abnormality, limitation or restriction not mentioned. Should any change in my health status occur, I will notify the college immediately.

Signature____Date______________________________

TO BE COMPLETED BY PHYSICIAN

List and date current illnesses.____

List and date all operations. ____

List and date past major injuries. ____

Describe and date past major illnesses. ____

____

Is there, or has there been any nervous, emotional or psychiatric abnormality? If so, give detail. _____________________________

____

Drug allergies ____

Current medications ____

REQUIRED IMMUNIZATIONS: Specific dates (month, date, and year) *If immunization information is not completed by physician performing physical, a photostatic copy of the original immunization records or documentation is required.*

Td within 10 years _____/_____/_____ (Tetanus only is not sufficient.)
MMR: 1st vaccine on or after first birthday _____/_____/_____
2nd vaccine _____/_____/_____
TB skin test (*Internationals only)* _____/_____/_____ ( ) negative ( ) positive (If positive, chest x-ray)

* *

Date _____/_____/_____ Sex _________Weight __________Height __________Temperature __________ Pulse __________

Respiration __________ Blood Pressure __________ Visual Activity: L __________ R __________

	NORMAL	ABNORMAL	DESCRIBE
Eyes\Vision			
Nose\Throat			
Mouth\Teeth			
Heart			
Abdomen			
Ears\Hearing			
Neck			
Lymph Nodes			
Chest\Lungs			
Extremities			
Neurological			
Skin\Scalp			
Urinalysis			
Spine			

Is this the first time you have examined this patient? ☐ Yes ☐ No
On the basis of your examination and knowledge, do you feel the applicant is physically and emotionally able to undertake a full college program of study and activities? ☐ Yes ☐ No
If no, explain. ____

Physician's name_____________________________________ Physician's signature ___________________________________

Address____ Phone (_______)______________