MEDICAL INFORMATION FORM

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

EMERGENCY CONTACT

Name: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: (___)_____ Work Phone: (___)_____

INSURANCE INFORMATION

Insurance Company_____
Member #: _____ Policy/Group No.: _____

PERSONAL HISTORY

Have any of you experienced/been diagnosed any of the following?

- ☐ ADD/ADHD
- ☐ Asthma/Bronchitis
- ☐ Bladder/Kidney Problems
- ☐ Cancer
- ☐ Chicken Pox/Shingles
- ☐ Clotting/Bleeding Disorders
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Eating Disorders
- ☐ Epilepsy/Seizures
- ☐ Fainting Spells/Dizziness
- ☐ Gut/Stomach Disorders
- ☐ Head Injury/Concussion
- ☐ Heart Disease/Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Lung Disease/TB
- ☐ Mental Health Issues
- ☐ Migraines/Headaches
- ☐ Mononucleosis
- ☐ Pregnancy/Miscarriage
- ☐ Thyroid Disease
- ☐ Other: _____

If you checked yes to any of these please explain:

_____

_____

_____

Do you have any allergies to food, medications, or environmental substances:

_____

List any serious injuries, hospitalizations, illnesses, surgeries, or operations:

_____

_____

Current Medications (prescriptions, vitamins/supplements, over-the-counter, etc.)

_____

_____

Do you currently or have you used:

☐ Alcohol ☐ Tobacco ☐ Marijuana ☐ Illicit/Illegal Drugs ☐ Vaping/Smoking

Please attach a copy of your Immunization Record and Insurance Card or send to one of the following:
Email: kmbc@kmbc.edu Fax: 1-888-742-1124
Mail: Office of Admissions, 855 HWY 541, Jackson, KY 41339

FAMILY HISTORY

Have any of your immediate biological family (parents, siblings, grandparents) experienced the following?

- ☐ ADD/ADHD
- ☐ Asthma/Bronchitis
- ☐ Bladder/Kidney Problems
- ☐ CancerClotting/Bleeding
- ☐ Disorders
- ☐ Depression/Anxiety
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Fainting Spells/Dizziness
- ☐ Gut/Stomach Disorders
- ☐ Heart Disease/Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Lung Disease/TB
- ☐ Mental Health Issues
- ☐ Thyroid Disease
- ☐ Other: _____

If you checked yes to any of these please explain:

_____

_____

CERTIFICATIONS

- I hereby authorize the medical personnel chosen by Kentucky Mountain Bible College, in case of injury to the student named on this form, to perform such assessment, interviews, tests, examinations, referrals, transportation, procedures, and treatments as may be necessary to relieve such conditions that I/they may encounter.
- If the injury or illness is life-threatening or in need of emergency treatment, I authorize summoning any and all professional emergency personnel to attend, transport, and treat me/my child and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care.
- It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power to Kentucky Mountain Bible College in the exercise of their best judgment upon the advice of any such medical or emergency personnel.
- I further agree to release Kentucky Mountain Bible College, its employees, agents, officers, staff and physicians for all loss, damage, and injury, including death, whatsoever arising in connection with medical treatment provided by or at Kentucky Mountain Bible College's direction.
- I understand that in the State of Kentucky, the age of majority is eighteen years old and at that age the student can provide consent for his or her medical and surgical procedures.
- I hereby affirm that the information provided on this form is complete and accurate to the best of my knowledge. I understand that withholding information requested or giving false information may make me ineligible or may result in dismissal from Kentucky Mountain Bible College. By signing this form I also permit this information to be released to appropriate KMBC staff and medical personnel in the case of a medical event.

(Must be signed by Parent/Guardian if the student is under eighteen)

Signature of Student: _____ Date: _____

Signature of Guardian (if under 18): _____ Date: _____

Relationship to Student: _____