



Student Health Form

Completed form is a requirement for enrollment at SEBC

OFFICE USE ONLY:
DATE COMPLETED: _____
HOLD REMOVED: _____

PLEASE PRINT:

Name: _____ Enrolling: _____ Year Fall Spring Summer
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Cell Phone: _____
 SSN: _____ DOB: _____ Sex: M F Marital Status: _____

IMMUNIZATION RECORD The following immunizations/tests are required. The form must be signed by a Health Care professional or have a Health Department stamp or a photocopy of official immunization records can be attached. We will not accept dates written in with no proof.

TUBERCULOSIS SCREENING PPD required regardless of prior BCG inoculation. Tine test not accepted. The test must be within **ONE YEAR** prior to enrollment at SEBC.
 DATE GIVEN: ___/___/___ DATE READ: ___/___/___ RESULTS: Positive ___ mm/Negative ___
 If PPD is positive, a chest x-ray is required.
 Date of chest x-ray: ___/___/___ RESULTS: Normal _____ Abnormal _____

TETANUS - DIPHTERIA Must be within last 10 years.
 DATE GIVEN: ___/___/___

M.M.R. (Measles/Mumps/Rubella) Required if born after 1956. Two doses required. Last dose must be since 1980.
 #1 ___/___/___ #2 ___/___/___

OR

RUBEOLA (Measles) Two doses required or positive immune titer. Copy of report required.
AND #1 ___/___/___ #2 ___/___/___
 Titer result and date: _____

MUMPS One dose required or positive immune titer. Copy of report required.
AND #1 ___/___/___ Titer Result and Date _____

RUBELLA (German Measles) One dose required or positive immune titer. Copy of report required.
 #1 ___/___/___ Titer Result and Date _____

- OPTIONAL IMMUNIZATIONS** Recommended but not required.
1. Meningococcal Meningitis Vaccine. The American College Health Association recommends all first year students living in residence halls receive the vaccine. Meningitis is a disease that causes severe swelling of the brain. DATE GIVEN: ___/___/___
 2. Varicella (Chicken Pox). Date of Disease _____ OR Vaccine #1 ___/___/___ #2 ___/___/___
 3. Hepatitis B Vaccine Series. #1 ___/___/___ #2 ___/___/___ #3 ___/___/___

THIS RECORD MUST BE SIGNED BY A HEALTH CARE PROFESSIONAL. (Health Department Stamp Acceptable)

MD/PA/NP/RN Signature: _____ Date: _____
 Print Name: _____ Office Phone: _____
 Address: _____

PLEASE COMPLETE BOTH SIDES OF THIS FORM BY DECEMBER 1 OR AUGUST 1 AND RETURN TO:

SOUTHEASTERN BIBLE COLLEGE
Attn: Student Life Office
2545 Valleydale Road
Birmingham, AL 35244

MEDICAL INSURANCE RECORD All SEBC students are required to have medical insurance. Please attach a copy of your insurance card (front and back) to this form. If you are not covered under a health insurance plan, you will be required to purchase student insurance from SEBC. Please mark one:

- Enclosed is a copy of my insurance card.
- I intend to purchase the school insurance. (checking this does not register you for the insurance. You will need to enroll and pay for the insurance at registration.)

MEDICAL HISTORY. Please circle all that apply.

Anemia	Epilepsy/Seizures	Injury to bones/Joints
Asthma	Frequent Anxiety	Kidney Disease
Back Problems	Hay Fever	Malaria
Depression	Hepatitis	Migraine Headaches
Diabetes	Heart Murmur	Rheumatic Fever
Ear Trouble	High Blood Pressure	Sickle Cell Disease
Eye Trouble	Infectious Mononucleosis	Stomach/Intestinal Trouble

Please list any other information not covered above (Operations, Hospitalizations, etc.)

Allergies. (Medications, Food, Insect Bites, etc.) Please be specific as to what allergic response you have (rash, breathing problems, etc.) _____

Current medications. _____

IN CASE OF EMERGENCY, NOTIFY

Name: _____ Relationship: _____

Phone: Home _____ Work _____

I authorize Southeastern Bible College to administer medical service, immunizations, diagnostic and therapeutic procedures as deemed necessary by duly licensed personnel. I will not hold Southeastern Bible College responsible for accident or injury directly incurred while _____ is on campus or while traveling for a school function.

Student Signature _____

****If the student is under 21 years of age and unmarried, then a parent or guardian must also sign.***

Signature: _____ Relationship to Student: _____

Address: _____ Phone: _____

I certify that I have fully disclosed my medical history, and that the information provided on this form is true.

Print Name: _____ Date: _____

Signature of Student: _____