

# River of Life School of Ministry

## HEALTH INFORMATION

**INSTRUCTIONS:** A history of disease and a physical examination are required for every applicant. Applicants are required to complete this medical history and have a physical examination done before the file is reviewed by the Admissions Office.

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### Part 1 (To be completed by the applicant.)

Date \_\_\_\_\_ Applicant's Name \_\_\_\_\_

Present Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Country \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ Country of Citizenship \_\_\_\_\_

Gender:  Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_  
Month Day Year

Social Security Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_

#### In case of emergency, please notify:

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

#### Parent or Guardian:

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

#### Family Physician:

Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

# HISTORY OF DISEASES

Please mark any of the following which apply.

Past	Now		Past	Now		Past	Now	
		Asthma			Thyroid Disturbance			Chicken Pox
		Hay fever			Convulsions			Measles
		Frequent Colds			Palpitations of Heart			Measles, German (rubella)
		Persistent Cough			Shortness of Breath			Mumps
		Spitting of Blood			Swelling of Feet			Tonsillitis
		Night Sweats			Back Trouble			Rheumatic Fever
		Eye Trouble			Frequent Headaches			Diabetes
		Ear Trouble			Insomnia			Epilepsy/ Convulsions
		Nasal Obstruction			Nervousness			Stomach Ulcer
		Fainting or Dizzy Spells			Frequent Urination			Tuberculosis
		Skin Trouble			Joint Trouble			HIV/AIDS
		Constipation			Indigestion			Gonorrhea
		Smallpox			Whooping Cough			Scarlet fever
		Diphtheria			Typhoid Fever			Pleurisy
		Malaria			Infantile Paralysis (Polio)			Appendicitis
		Syphilis			Other Illness			Other Disturbance

Have you had a skin test for tuberculosis?  Yes  No

Date administered: \_\_\_\_\_ Results:  Positive  Negative

Have you been associated with a tuberculosis patient?  Yes  No When? \_\_\_\_\_

Are you allergic to any antibiotics or other medications?  Yes  No

If yes, please specify: \_\_\_\_\_

Are you presently under a medical doctor's care?  Yes  No

If yes, for what? \_\_\_\_\_

Are you taking prescription medicines?  Yes  No

If yes, what? \_\_\_\_\_

Have you suffered a nervous breakdown?      Yes    No

If yes, please explain: \_\_\_\_\_

Have you ever been under a doctor's care for an emotional disorder?      Yes    No

If yes, please explain: \_\_\_\_\_

What institution? \_\_\_\_\_

### IMMUNIZATION RECORD

	Date	Date	Date	Date
<b>DTP</b>				
<b>TD or Tetanus</b>				
<b>Polio</b>				
<b>Rubella (Measles)</b>				
<b>Mumps</b>				
<b>Rubella (German Measles)</b>				

## PART II: PHYSICAL EXAMINATION

(To be completed by physician)

Height \_\_\_\_\_ Weight \_\_\_\_\_ Heart \_\_\_\_\_

Blood Pressure \_\_\_\_\_ Nose and throat \_\_\_\_\_

Sinuses \_\_\_\_\_ Teeth \_\_\_\_\_

Skin \_\_\_\_\_ Eyes \_\_\_\_\_

Are there any thyroid or glandular difficulties? \_\_\_\_\_

Are there any weaknesses or limitations? \_\_\_\_\_

Do you consider the applicant's health adequate for intensive school work?  Yes  No

Remarks \_\_\_\_\_

\_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

# River of Life School of Ministry

## MEDICAL CONSENT

I, the undersigned, do hereby state that on the date indicated I grant full permission to River of Life School of Ministry, or any related or consulting physician, to render or give emergency medical care or treatment that is deemed necessary. I also state that, should extended hospitalization be required, I grant complete permission for such care and treatment to be given. I also state that by granting such permission, I absolve River of Life School of Ministry of any financial liability pertaining to such medical treatment or hospitalization.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Health Records will be held in strict confidence as with all other materials submitted in application to RLSM. The applicant is to sign below that he/she has read this statement and thereby authorizes RLSM to release necessary health information in emergency or life-threatening situations. (If applicant is under 18 years, he/she should have his/her parents or guardian co-sign.)

\_\_\_\_\_  
Applicant

\_\_\_\_\_  
Parent/Guardian

Please return Health Information & Medical Consent to:  
River of Life School of Ministry  
Attn: Dean of Students  
677 South Dickinson Dr.  
Rusk, TX 75785  
USA