	# See A Man Be A Man Mentoring program of Board of Men's Ministries Church of Christ of the Apostolic Faith Jesse L. Gamble, Mentoring Program Chairman Ernest Walker, Director/Chairman District Elder Eugene Lundy, M.D., M.B.A., D.D., Pastor

Student Health History

Name: ____
Address: ____
City: __________________________ State: ______________

Health/accident insurance company: ____________________________
Policy Number: ______________

Have or subject to (check if yes):

☐ Asthma
☐ Diabetes
☐ Fainting spells
☐ Heart trouble
☐ Convulsions
☐ Bleeding disorders
☐ Allergy to any medication, food, plant, animal, or insect toxin
☐ Any condition that may require special care, medication, or diet

Explain: ____

Check here if none of the above applies ☐

Have difficulty with (check if yes): ☐ Eyes, ears, nose, throat ☐ Digestion ☐ Bed-wetting ☐ Lungs ☐ Sleepwalking

Any condition now requiring regular medication?___________________________

Name of medication: ____

Are there any restrictions of activity for medical reasons? ____ Explain ___________

____

Immunizations	Date of last inoculation		Date of last inoculation		Date of last inoculation
Tetanus toxoid	______	Polio	______	Mumps	______
Diphtheria	______	Measles	______	Rubella	______
Pertussis	______		______		______

Parent Authorization

This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed activities, except as noted by me. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the adult leader in charge to hospitalize, secure proper anesthesia, or to order injection for my son.

Signature____ Date:_____
Parent or guardian

Home telephone number_________________________ Business telephone number______________