



HARVEST DEAF BIBLE COLLEGE

STUDENT HEALTH FORM AND CONSENT FOR TREATMENT

PERSONAL INFORMATION:

Student's name: _____

Social Security Number: _____

DOCTOR EXAMINATION:

Please have a doctor fill out a statement the status of your physical health within six months of entering the college. Have the doctor send it directly to the college address given below. Have your doctor verify that you have had all the shots for the childhood diseases.

I have seen the doctor on _____ and a statement from the doctor will be sent to the Harvest Deaf Bible College.

COVERED HEALTH INSURANCE:

If covered, name of Insurance Company: _____

Policy number: _____

Group number: _____

MEDICARE:

Do you have Medicare? YES NO

NOT COVERED:

If you are not covered by any health insurance plan, the Harvest Deaf Bible College does not provide health insurance or pay for any medical expenses for students.

How do you plan to pay for your medical expenses should the need arise? _____

PERSONAL DOCTOR:

Name of your doctor: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

CHILDHOOD DISEASES:

Have you had all of your childhood disease shots? YES NO DON'T KNOW

If no, which shots do you need? _____

EMERGENCY: Who can the Harvest Deaf Bible College call in case of an emergency?

Name of emergency contact: _____

Relation to prospective student: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Work phone number: _____

SIGNATURE:

I declare that the information given on this health form is complete and accurate.

Applicant's signature Date

PARENT OR LEGAL GUARDIAN CONSENT
(only if the prospective student is under twenty-one years of age)

In an event of a medical emergency, I hereby give permission to the staff of the Harvest Deaf Bible College to hospitalize and/or secure the services of a licensed physician, surgeon, and/or anesthetist in providing the necessary care for my child if the emergency contact or I is unavailable for contact.

I declare that the information given on this health form is complete and accurate.

Parent's or Legal Guardian's signature Date

Home phone number Work phone number

Mail this health form to:
(This is the address for the doctor to
send his health evaluation.)

Harvest Deaf Bible College
Office of Registrar
1314 Old Three Notch Road
Ringgold, GA 30736