

**CALEB LEADERSHIP TRAINING SCHOOL**  
**STUDENT HEALTH FORM**

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle: \_\_\_\_\_

Home phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Medical information:**

Name of insurance carrier: \_\_\_\_\_ Contact phone: \_\_\_\_\_

Policy type: \_\_\_\_\_ Policy number: \_\_\_\_\_ Expiration date: D \_\_\_\_\_ M \_\_\_\_\_ Y \_\_\_\_\_

Brief description of coverage: \_\_\_\_\_

In case of emergency contact: \_\_\_\_\_

Relationship: \_\_\_\_\_

Street/Box: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Health history:** (Answer all questions. Explain positive answers below or on a separate piece of paper.)

Do you now have, or have you ever had, any of the following?

- | Yes                      | No                       |                            | Yes                      | No                       |                                 | Yes                      | No                       |                          |
|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|---------------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 1-Skin condition           | <input type="checkbox"/> | <input type="checkbox"/> | 15-Heart trouble                | <input type="checkbox"/> | <input type="checkbox"/> | 25-Jaundice              |
| <input type="checkbox"/> | <input type="checkbox"/> | 2-Eye trouble              | <input type="checkbox"/> | <input type="checkbox"/> | 16-High blood pressure          | <input type="checkbox"/> | <input type="checkbox"/> | 26-Hepatitis             |
| <input type="checkbox"/> | <input type="checkbox"/> | 3-Ear trouble              | <input type="checkbox"/> | <input type="checkbox"/> | 17-Low blood pressure           | <input type="checkbox"/> | <input type="checkbox"/> | 27-Intestinal troubles   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4-Head injury              | <input type="checkbox"/> | <input type="checkbox"/> | 18-Rheumatism/Arthritis         | <input type="checkbox"/> | <input type="checkbox"/> | 28-Recurrent diarrhea    |
| <input type="checkbox"/> | <input type="checkbox"/> | 5-Recurrent headache       | <input type="checkbox"/> | <input type="checkbox"/> | 19-Back problems                | <input type="checkbox"/> | <input type="checkbox"/> | 29-Diabetes              |
| <input type="checkbox"/> | <input type="checkbox"/> | 6-Epilepsy                 | <input type="checkbox"/> | <input type="checkbox"/> | 20-Dislocation of joints        | <input type="checkbox"/> | <input type="checkbox"/> | 30-Kidney disease        |
| <input type="checkbox"/> | <input type="checkbox"/> | 7-Fainting spells          | <input type="checkbox"/> | <input type="checkbox"/> | 21-Broken bones                 | <input type="checkbox"/> | <input type="checkbox"/> | 31-Anemia                |
| <input type="checkbox"/> | <input type="checkbox"/> | 8-Mental/Nervous disorders | <input type="checkbox"/> | <input type="checkbox"/> | 22-Stomach/Duodenal ulcer       | <input type="checkbox"/> | <input type="checkbox"/> | 32-Gall bladder problems |
| <input type="checkbox"/> | <input type="checkbox"/> | 9-Depression               | <input type="checkbox"/> | <input type="checkbox"/> | 23-Sexually transmitted disease | <input type="checkbox"/> | <input type="checkbox"/> | 33-Cancer/Tumors         |
| <input type="checkbox"/> | <input type="checkbox"/> | 10-Paralysis               | <input type="checkbox"/> | <input type="checkbox"/> | 24-Surgery                      | <input type="checkbox"/> | <input type="checkbox"/> | 34-Female conditions     |
| <input type="checkbox"/> | <input type="checkbox"/> | 11-Insomnia                | <input type="checkbox"/> | <input type="checkbox"/> | Appendectomy                    | <input type="checkbox"/> | <input type="checkbox"/> | Irregular periods        |
| <input type="checkbox"/> | <input type="checkbox"/> | 12-Shortness of breath     | <input type="checkbox"/> | <input type="checkbox"/> | Tonsillectomy                   | <input type="checkbox"/> | <input type="checkbox"/> | Severe cramps            |
| <input type="checkbox"/> | <input type="checkbox"/> | 13-Hay fever/Asthma        | <input type="checkbox"/> | <input type="checkbox"/> | Hernia repair                   | <input type="checkbox"/> | <input type="checkbox"/> | Excessive flow           |
| <input type="checkbox"/> | <input type="checkbox"/> | 14-Allergies               | <input type="checkbox"/> | <input type="checkbox"/> | Other                           | <input type="checkbox"/> | <input type="checkbox"/> | Now pregnant             |

Specify: \_\_\_\_\_ Specify: \_\_\_\_\_ Other: \_\_\_\_\_

Other illnesses or conditions: \_\_\_\_\_

Explanations for above: \_\_\_\_\_

Are you presently under a doctor's care?  Yes  No Specify: \_\_\_\_\_

Are you presently taking any medication?  Yes  No Specify: \_\_\_\_\_

Are you allergic to any drugs/medications?  Yes  No Specify: \_\_\_\_\_

Are you now receiving or did you ever receive compensation for disability from any source?  Yes  No Specify: \_\_\_\_\_

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**Disease history:**

Have you ever had any of the following COMMUNICABLE DISEASES?

- |                          |                          |                     |                          |                          |
|--------------------------|--------------------------|---------------------|--------------------------|--------------------------|
| Yes                      | No                       |                     | Yes                      | No                       |
| <input type="checkbox"/> | <input type="checkbox"/> | 1-Chickenpox        | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | 2-Measles (rubella) | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | 3-Measles (rubeola) | <input type="checkbox"/> | <input type="checkbox"/> |
|                          |                          |                     | <input type="checkbox"/> | <input type="checkbox"/> |
|                          |                          |                     | <input type="checkbox"/> | <input type="checkbox"/> |
|                          |                          |                     | <input type="checkbox"/> | <input type="checkbox"/> |

**Family history:**

Have any of your immediate family members ever had any of the following?

- |                          |                          |                  |                          |                          |
|--------------------------|--------------------------|------------------|--------------------------|--------------------------|
| Yes                      | No                       |                  | Yes                      | No                       |
| <input type="checkbox"/> | <input type="checkbox"/> | 1-Tuberculosis   | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | 2-Diabetes       | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | 3-Kidney disease | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | 4-Heart disease  | <input type="checkbox"/> | <input type="checkbox"/> |
|                          |                          |                  | <input type="checkbox"/> | <input type="checkbox"/> |
|                          |                          |                  | <input type="checkbox"/> | <input type="checkbox"/> |
|                          |                          |                  | <input type="checkbox"/> | <input type="checkbox"/> |

**Immunizations:**

	DISEASE BASIC (year)			BOOSTER (year)		
	1st dose	2nd dose	3rd dose	1st dose	2nd dose	3rd dose
Diphtheria:	_____	_____	_____	_____	_____	_____
Tetanus:	_____	_____	_____	_____	_____	_____
Pertussis:	_____	_____	_____	_____	_____	_____
Polio:	_____	_____	_____	_____	_____	_____
Rubella:	_____	_____	_____	_____	_____	_____
Mumps:	_____	_____	_____	_____	_____	_____
Hepatitis A:	_____	_____	_____	_____	_____	_____

Please mail this form to: **Caleb Company, P.O. Box 493 Thompson's Station TN 37179-0493**  
Phone: (615) 256-2123 Ext 224 Fax: (615) 254-3190 Email: [admin@calebcompany.com](mailto:admin@calebcompany.com)