

## PERSONAL INFORMATION

**Name:**

**Home  
Telephone:**

**Email  
Address:**

**Application  
ID:**

**Date of  
Birth:**

## WHAT THIS FORM IS FOR

Please print out this form and fill it in. You can then either fax back this document to us or you can scan it back in and upload it to us, along with your personal history and the release and consent form.

Visit <http://gracecenter.us/school> for more details.

## HEALTH FORM

*TO THE APPLICANT: This information will be treated confidentially and separately from your academic records. Please complete the first part of this form and then have your doctor complete the rest. Please answer ALL the following questions in ink or by typing in ENGLISH.*

### PERSONAL HISTORY

**Have you ever had, or do you have, any of the following?  
If Yes, please give the details on a separate sheet.**

|  |                       |  |                           |  |                           |
|--|-----------------------|--|---------------------------|--|---------------------------|
|  | Skin condition        |  | Heart trouble             |  | Jaundice                  |
|  | Eye trouble           |  | Hepatitis                 |  | HIV                       |
|  | High blood pressure   |  | Head injury               |  | Low blood pressure        |
|  | Intestinal problems   |  | Arthritis                 |  | Recurrent diarrhea        |
|  | Recurrent headache    |  | Back problems             |  | Diabetes                  |
|  | Epilepsy              |  | Kidney disease            |  | Fainting spells           |
|  | Dislocation of joints |  | Broken bones              |  | Mental / nervous disorder |
|  | Anemia                |  | Venereal disease          |  | Stomach / duodenal ulcer  |
|  | Weakness              |  | Tumor / cancer            |  | Gall bladder problems     |
|  | Paralysis             |  | Surgery                   |  | Insomnia                  |
|  | Appendectomy          |  | Tonsillectomy             |  | Shortness of breath       |
|  | Hay fever             |  | Asthma                    |  | Hernia repair             |
|  | Ear trouble           |  | Allergies, including food |  | Other                     |

**Have you ever had any of the following?**

|  |                   |  |                  |  |                            |
|--|-------------------|--|------------------|--|----------------------------|
|  | Measles (Rubella) |  | Measles (German) |  | Chicken pox                |
|  | Mumps             |  | Hypertension     |  | Pertussis (whooping cough) |
|  | Scarlet fever     |  | Tuberculosis     |  |                            |
|  | Epilepsy          |  | Convulsions      |  |                            |