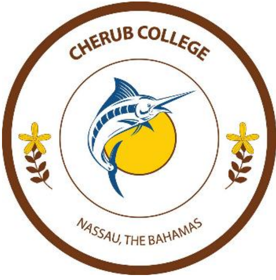


CONFIDENTIAL

Medical Form

This form is required as a part of the Admissions Procedure. It must be completed by a licensed medical physician. This form must be submitted prior to starting a course. Although some physicians may charge for medical examinations, it is a course to be borne solely by the student. The information on this form will provide the basis for your personal confidential Medical Records which will be kept by the college.

TO BE COMPLETED BY STUDENT:

1. Personal Information

Legal Name:____
Last First Middle Maiden

Gender: ☐Male ☐Female **Date of Birth:** ____/___________/______ **Citizenship:** ____________________
Day Month Year

National Insurance Board #: ____________________________ **Religion:** ________________________________

2. Emergency Contact

Name: ____**Relationship To You:** ________________________

Address: ____

Telephone: *home*_______________________ work _______________________ *cell* _______________________

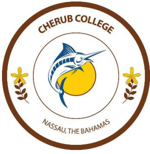
Place of Employment: _______________________________ **Email:** ______________________________________

3. Personal Statement

I certify that the information contained in this form and reported to the medical physician is true and complete. No materials have been intentionally withheld or omitted and I understand that the information will be made available to the respective health authorities if the need arises.

Signature of Student: ____ Date: _______________________________

Signature of Parent: ____ Date: _______________________________
(Only if student is under age 18.)



Medical Form

TO BE COMPLETED BY MEDICAL PRACTITIONER:

Height: ______________________ Weight: ______________________ Blood Pressure: ______________________

Immunization Record: Has the student been immunized against the following? Please give approximate dates where exact dates are not available. We strongly recommend that all students be up to date with all relevant immunizations prior to the commencement of classes.

Tetanus Toxoid: ___________________________________ Poliomyelitis: _____________________________________

BCG or Heaf:
For TB ____

Rubella:
German Measles: _________________________________

Others (eg. Hepatitis B, Measles, Mumps, Rubella): ____

For Women Only if applicable – Date of last Cervical Smear: ____

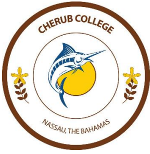
Is the student currently prescribed any medication? ☐ YES ☐ NO

If yes, indicate the name of medication and medical condition. Specify dosage and frequency. ______________________

____

Has the student ever had or been treated for the following? All yes answers require further explanation.

Heart Disease, High Blood Pressure, Varicose Veins, or Circulatory System disease.	☐ Yes	☐ No
Diabetes, Goitre, or any Glandular Disease.	☐ Yes	☐ No
Epilepsy, Fainting Attacks, or other diseases of the Brain or Nervous System.	☐ Yes	☐ No
Fistula, Fissure, Hemorrhoids, or other diseases of the Rectum.	☐ Yes	☐ No
Cancer or Tumor, Syphilis or Tuberculosis.	☐ Yes	☐ No
Asthma, Pleurisy, or other disease of the Respiratory Tract.	☐ Yes	☐ No
Migraine or Headaches.	☐ Yes	☐ No
Glandular Fever.	☐ Yes	☐ No
Any Viral Illness.	☐ Yes	☐ No
Hepatitis.	☐ Yes	☐ No
Malaria.	☐ Yes	☐ No
Neck or Back Strain or Injury or Hernia.	☐ Yes	☐ No
Any deformity or loss of limb.	☐ Yes	☐ No
Any disease of the Reproductive Organs.	☐ Yes	☐ No
Psychological/Psychiatric difficulties requiring treatment and/or medication.	☐ Yes	☐ No
Emotional Difficulties including Depression, Phobias, Anxiety states etc…	☐ Yes	☐ No
Anorexia, Bulimia, or any other eating disorders.	☐ Yes	☐ No
Ulcers or disease of the stomach, intestines, liver, gall-bladder, or Gastrointestinal tract.	☐ Yes	☐ No
Sugar in urine, Kidney Disease, or disease of the genitourinary tract.	☐ Yes	☐ No



Medical Form *continued*

TO BE COMPLETED BY MEDICAL PRACTITIONER:

Arthritis, Rheumatism, or other disease of the Bones.	☐ Yes	☐ No
Impairment of sight, speech or hearing, or disease of the Eye, Ear, Nose or Throat.	☐ Yes	☐ No
Surgical procedure performed or advised to have been performed in the past 5 years?	☐ Yes	☐ No
Substance Abuse.	☐ Yes	☐ No
Allergic Reactions to food, environment or drugs.	☐ Yes	☐ No
Special dietary needs, preferences, or difficulties.	☐ Yes	☐ No
Menstrual problems including irregular/painful periods and pre-menstrual syndrome.	☐ Yes	☐ No
Any other illnesses, diseases, or treatments not mentioned above in the past 5 years.	☐ Yes	☐ No

Are you aware of the student having any learning difficulties? If so, please explain:

____

____

____

____

Any other information you feel is necessary to share?

____

____

____

____

Physicians Name: ________________________________ **Signature:** ____________________________________

Date: ______________________ **Telephone:** _________________________ **Fax:** _________________________

Address: ____

PHYSICIANS STAMP: