MEDICAL FORM

(all answers will be kept confidential)

1. Students Name: ______________________________

2. Have you or any member of your family suffered from:

   ☐ Tuberculosis ☐ Epilepsy ☐ Emotional Disturbances ☐ Heart Disease

   ☐ Asthma ☐ Diabetes ☐ Digestive Tract Diseases ☐ Other

   If yes, give details. Use a separate sheet if necessary: ______________________________

3. Please list any hospitalizations and diagnosis: Please include details and dates: ______________________________

4. Have you ever received psychological counceling? ☐ Yes ☐ No

   If yes please give details: ______________________________

5. Are you allergic to any medications? ☐ Yes ☐ No

   If yes, indicate which medications: ______________________________

6. List any other allergies: ______________________________

7. Have you ever suffered from an eating disorder? ☐ Yes ☐ No

   If yes please give details: ______________________________

SUBMIT THIS FORM ALONG WITH YOUR CURRENT IMMUNIZATION RECORDS FROM YOUR DOCTOR