Confidential Health Form

Full Name _____ Gender _____

Date of Birth _____ School Applying For _____ Beginning Date _____

Height _____ Weight _____

Personal History: Please answer all questions. Have you ever had the following conditions or procedures? Explain any "Yes" answers in the space provided.

O Skin Condition _____

O Eye Trouble _____

O Ear Trouble _____

O Head Injury _____

O Epilepsy _____

O Fainting Spells _____

O Mental Nervous Disorder _____

O Weakness _____

O Paralysis _____

O Insomnia _____

O Shortness of Breath _____

O Hay Fever/Asthma _____

O Heart Trouble _____

O High Blood Pressure _____

O Low Blood Pressure _____

O Rheumatism/Arthritis _____

O Back Problems _____

O Dislocation of Joints _____

O Broken Bones _____

O Eating Disorder _____

O Stomach/Duodenal Ulcer _____

O Gall Bladder Problems _____

O Intestinal Troubles _____

O Recurrent Diarrhea _____

Confidential Health Forms (Continued)

O Kidney Disease _____

_____

O Anemia _____

_____

O Venereal Disease _____

_____

O Tumor/Cancer _____

_____

O Jaundice _____

_____

O Hepatitis _____

_____

Allergies

O Food _____

_____

O Penicillin _____

_____

O Sulfonamides _____

_____

O Serum _____

_____

O Other _____

_____

Surgery

O Appendectomy _____

_____

O Hernia _____

_____

O Tonsillectomy _____

_____

O Other _____

_____

Females Only

O Irregular Periods _____

_____

O Severe Cramping _____

_____

O Excessive Flow _____

_____

O Current Pregnancy _____

_____

O Previous Pregnancy _____

_____

Explain any other health issues, medical conditions, or physical handicaps. _____

_____

Are you currently under a doctor's care for any condition? _____

Are you taking medication at this time? _____

_____

Do you have a history of emotional instability or psychiatric treatment? _____

_____

Confidential Health Forms (Continued)

Blood Type _____

Have you had any of the following?

O Chicken Pox O Measles/Rubella O Tuberculosis O Pertussis
O Scarlet Fever O Mumps O Other _____

Have you or any of your relatives ever had any of the following communicable diseases?

O Tuberculosis _____ O Hay Fever _____
_____ _____
O Arthritis _____ O Heart Disease _____
_____ _____
O Diabetes _____ O Convulsions _____
_____ _____
O Stomach Disease _____ O Epilepsy _____
_____ _____
O Kidney Disease _____ O Hypertension _____
_____ _____
O Asthma _____ O Cancer _____
_____ _____

If necessary, are you able to walk 3-4 miles per day? O Yes O No

Insurance

Health Insurance Company _____

Insurance Policy Number _____

Emergency Contact

Name(s) _____ Relationship _____

Phone ( )_____ O Home O Cell O Work

Additional ( )_____ O Home O Cell O Work