Medical Records Form

To be completed and signed by the student's Physician

Student Name: ____

Health Card #: _________________________________

Doctor: ______________________________________

Doctor's Address: Doctor's Phone:
____

Complete Medical:☐Yes ☐No *Follow-Up Required: ☐Yes ☐No

Date of Last Blood Work: _________________ *Any Concerns: ☐Yes ☐No

Date of Last Internal/Pap Test: ______________________

Date of Late Period or Pregnancy Test, Specify:
____

The following are required testing for admittance into the program:

STI Test: ☐
TB Test: ☐
HIV Test: ☐
Hep B Test: ☐

Hep B Vaccine: ☐
Hep C Test: ☐
Date of Last Tetanus Shot: _________

NOTE: Please provide copies of completed lab work.

***Allergies:**

____
____
____
____
____
____
____
____

Food Allergies:____
____
____
____

Do you suffer from asthma or require and Epi pen: ☐Yes ☐ No

***Current Medications and Details:**

____
____
____
____
____
____

Medical Alert Information: ____

***Any other Medical Problems to Be Aware of: ☐Y ☐N**
If yes explain:

____
____
____
____
____
____
____

Physicians Name: ______________________________________

Physicians Signature: __________________________________

Date: ______________________