Colbourne College

Medical History Form

Applicant Self-Disclosure of Medical History and Information to review with your Physician before sending to Colbourne College

This form is to be filled out completely by the applicant and a Physician and returned to the Admissions office. This information is confidential and will be kept on file. The information herein will be used only in case of an emergency or medical situation.

Date: ______________________________ Student ID: _______________________

Student Full Name: ____

Campus: _______________________________ Semester: _________________________

Home Address: ____

Phone: (   ) _____________________________ Birth date: ________________________

Height: ___________________ Weight: ________________ (   ) male (   ) female

IN CASE OF EMERGENCY NOTIFY:

Name: _______________________________________ Relationship: ____________________

Phone: _____________________________________ Email: _________________________

Address: ____

Family History:

Physician Name: ___________________________ Physician's ph. #:___________________

To the applicant: please circle Yes or No for each item. Each question must be answered.

GENERAL MEDICAL HISTORY

Do you currently have or have you had a history of:

1. Respiratory problems? (e.g., asthma) — 1. Yes No
2. Gastrointestinal conditions? (e.g., heartburn) — 2. Yes No
3. Diabetes? — 3. Yes No
4. Specific comments:

____

____

4. Hypertension? — 4. Yes No

5. Bleeding or blood disorders? — 5. Yes No

6. Hepatitis or other liver disease? 6. Yes No

Specific comments:

____

____

7. Neurological problems? (e.g., seizure disorder) 7. Yes No

8. Dizziness or fainting episodes? 8. Yes No

9. Cardiac problems? 9. Yes No

Specific comments:

____

____

10. Disorders of the urinary or reproductive tract? 10. Yes No

11. Any other medical conditions or considerations that may affect your participation (including loss of

hearing or vision)? 11. Yes No

Specific comments: ____

12. Do you see a Medical or Physical specialist of any kind? 12. Yes No

Physician Name____

Address ____

13. Are you pregnant? 13. Yes No

Specific comments:

____

____

PERSONAL HISTORY (COUNSELLING/PSYCHIATRIC)

14. Have you had treatment or counseling with a mental health professional? 14. Yes No

15. Are you currently in treatment or counseling? 15. Yes No

16. Name and address of therapist

____

17. Hospitalization within the past year? 17. Yes No

18. Reasons for treatment or counseling?

____suicide gesture

____substance abuse/chemical dependency

____eating disorder (anorexia/bulimia)

____other (please give specifics below)

____academic/career

____family issues/divorce

____learning disability

Specific comments:

____

____

ALLERGIES

19. Any environmental allergies? _______________________________ 19. Yes No

20. Is iodine contraindicated for you? 20. Yes No

21. Are you allergic to any foods? Do you have any dietary restrictions? 21. Yes No

____

22. Allergies to insect bites or bee stings? 22. Yes No

Specific comments: ____

23. Date of Last Tetanus Immunization? ________________

MEDICATIONS

24. Are you allergic to any medications?_______________________ 23. Yes No

25. Are you currently taking any medications? Please specify dose. 24. Yes No

Medication Dosage (amt./freq.) Side Effects/Restrictions

____

____

26. History of heat stroke or other heat related illness? 26. Yes No

Specific comments:

____

____

FITNESS

27. Do you exercise regularly? 27. Yes No

Intensity Level

Activity Frequency Duration/Distance Easy Moderate Competitive

____

____

28. Do you smoke? If so, how much?_______________ 28. Yes No

29. Are you in an appropriate weight range for your height? 29. Yes No

30. Swimming Ability (check one): ____non-swimmer ____recreational ____competitive

Physician Physical Examination

To be completed by the Physician only: **Sign and use Medical Practice Stamp to authenticate**

Applicant/Patient's Name: ____

Blood Pressure:__________________________ Pulse:____________________________

Cardio-respiratory exam __________________________________

Have you reviewed the applicant's Medical History Form (4 pages)? Yes ___ No ___

Please comment on specific areas from the Medical History Form that need elaboration.

____

____

____

This individual may be required to participate in physical exercises and swimming. Based on the information
provided in the Medical History Form, their medical history self-disclosure and the physical examination, do you
feel that this individual can participate in these Programs?

____ YES, I think this person can participate

____ MAYBE, if the following restrictions or concerns can be accommodated in the program

____ NO, this person should not participate at this time for the reasons below

Comments (reasons, restrictions, or concerns):

____

____

____

Examiner's Name:____

Phone:_______________________________________ Email: ______________________________

Address: ____

PHYSICIAN SIGNATURE:_____________________________________ DATE:_________________

Please return all original pages (including the 4 page Medical Form) to:

Admissions Office
Colbourne College, 6 Hillview Avenue, Kingston 10
Phone: (876)906-8085/ 906-0918 **Fax:** (876) 906-8401 **Email**: admin@colbournecollege.com