KINGSWAY CHRISTIAN COLLEGE
INTERNATIONAL STUDENTS MEDICAL HISTORY FORM

NAME OF STUDENT		
DATE OF BIRTH:	Male ☐ Female ☐	NATIONALITY:
Instructions: Please tick the appropriate box . If you tick ' YES' to any of these questions, please add an explanatory note in the column provided.		
Heart Disease/Disorder	Yes ☐ No ☐	*Comments*
Diabetes	Yes ☐ No ☐	
Epilepsy	Yes ☐ No ☐	
Dietary Problems	Yes ☐ No ☐	
Broken Bones/Spinal Injury	Yes ☐ No ☐	
Cancer/Leukemia	Yes ☐ No ☐	
Hepatitis	Yes ☐ No ☐	
Blood pressure	Yes ☐ No ☐	
Mental illness /Depression	Yes ☐ No ☐	
ADD/ADHD (Hyper active/Attention Deficit Disorder)	Yes ☐ No ☐	
Asthma	Yes ☐ No ☐	
Any Fevers	Yes ☐ No ☐	
Measles/Chicken Pox	Yes ☐ No ☐	
Thyroid Function Problems	Yes ☐ No ☐	

		Comments
Please state your Blood Group if known	Unknown ☐	Blood group:
Female Students: Do you have menstrual problems?	Yes ☐ No ☐	
Hearing/Speech/Sight difficulties	Yes ☐ No ☐	
Are you allergic to anything? *(i.e. peanuts, dust, pollen, beestings, etc)*	Yes ☐ No ☐	
Any other problems please give the details:		

Do you take any medications al all? If "YES", please list them and how often you take them. Include **ALL** prescribed medications, herbal preparations, vitamins or minerals.

NAME OF YOUR DOCTOR:

TELEPHONE NUMBER OF YOUR DOCTOR:

ADDRESS OF YOUR DOCTOR:

SIGNATURE : ____ DATE: _________________________

NAME *(Please Print)*____

Student (or Parent if student is under 18 years of age)

PLEASE ATTACH ANY ADDITIONAL INFORMATION.

THIS FORM MUST BE RETURNED TO THE INTERNATIONAL STUDENT OFFICE.