LONG BAY COLLEGE
Success with confidence and creativity
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STUDENT MEDICAL RECORD (CONFIDENTIAL)

Students Last Name:_____ First Name:_____

Gender:_____ Date of Birth:_____

Personal History: Please mark Yes/No		Specify treatment/medication
Allergies	Yes/No	_____
Asthma, chronic	Yes/No	_____
Asthma, exercise induced	Yes/No	_____
Cancer	Yes/No	_____
Dizziness/Fainting	Yes/No	_____
Depression/Mental Illness	Yes/No	_____
Epilepsy	Yes/No	_____
Eye Problems	Yes/No	_____
Head injury	Yes/No	_____
Headache, recurrent	Yes/No	_____
Heart condition	Yes/No	_____
Hepatitis	Yes/No	_____
HIV/Aids	Yes/No	_____
Stomach disorder	Yes/No	_____
Thyroid disorder	Yes/No	_____

Indicate any other chronic concerns or disabilities:_____

_____

_____

_____

List any previous injury:_____

_____

_____

_____

Hospitalizations: (Give reasons and dates)

_____

_____

_____

_____

Contact (in your home country) in case of emergency:

Name:_____

Tel: (h)_____

(w)_____

(Cell)_____

E-mail_____

Relationship to student:_____