

# STUDENT MEDICAL FORM

Return To: Coordinator of Health and Wellness, Olds College  
4500 50 ST, Olds, AB T4H 1R6



**PLEASE COMPLETE THIS FORM AND RETURN TO OLDS COLLEGE**

It is **not** necessary for a doctor to complete this form. This information is **CONFIDENTIAL**.

**PLEASE DIRECT QUESTIONS TO Coordinator of Health and Wellness at 1800 661-6537 OR 403 556-8281**

## PERSONAL DATA

Last Name: _____	Given Names: _____
Home or Permanent Address: _____ _____	Alberta Provincial Health #: _____
Phone: (     ) _____	Out of Province Health Number: _____
Date of Birth: _____	Next of Kin in case of Emergency: _____
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Relationship: _____
Program: _____	Phone Number: (     ) _____

## HEALTH HISTORY - (Please check YES or NO for each of the following)

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<b>Serious Eye Condition</b> <i>Describe: _____</i>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Heart Condition</b> <i>Describe: _____</i>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Hearing Loss</b> <i>Describe: _____</i>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Stomach/Intestinal Disorder</b> <i>Describe: _____</i>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Head injury with loss of consciousness in last five years?</b>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Knee, shoulder, or other joint injury</b> <i>Describe: _____</i>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Seizures/Epilepsy</b> <i>Frequency: _____</i> <i>Date of Last Seizure: _____</i>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Emotional Difficulties</b> <i>Describe: _____</i>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Back Condition</b> <i>Describe: _____</i>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Cancer or Tumors</b> <i>Describe: _____</i>
<input type="checkbox"/>	<input type="checkbox"/>	<b>Diabetes</b> <i>Age of Onset: _____</i> <i>Date of last insulin reaction: _____</i>	<input type="checkbox"/>	<input type="checkbox"/>	<b>Asthma</b> <i>Frequency of attacks: _____</i> <i>Date of last attack: _____</i>
<input type="checkbox"/>	<input type="checkbox"/>	<b>ALLERGIES? PLEASE LIST</b> _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<b>Thyroid Disorder</b>
			<input type="checkbox"/>	<input type="checkbox"/>	<b>Tuberculosis</b>

Please note any disease or disability (including physical, learning, or psychological) not already mentioned:

\_\_\_\_\_

Please list current medication or pills: \_\_\_\_\_

\_\_\_\_\_

## IMMUNIZATION RECORD

Attach a copy of your immunization record (ask your Public Health Unit) OR fill out appropriate information.

Tetanus/Diphtheria*	Date	_____	Measles/Mumps/Rubella	Date	_____
Polio	Date	_____	Meningococcal	Date	_____
Rabies	Date	_____	Hepatitis B completed	Date	_____
(AHT/VMR)**					
Other	Date	_____	Other	Date	_____

\* Tetanus/Diphtheria must be updated every ten years.

\*\* Students in AHT/VMR require a rabies series. **DO NOT** start the series. You will receive it at Olds College.

Signature of Applicant \_\_\_\_\_

Date \_\_\_\_\_

This information is collected under the authority of the Freedom of Information and Protection of Privacy Act. Public inquiries regarding the collection, use and disclosure of personal information provided on this form should be directed to the FOIP Coordinator, Olds College at 4500 50 ST, Olds, AB, T4H 1R6.