MEDICAL FORM

1) TO BE FILLED IN BY THE APPLICANT WITH THE HELP OF A MEDICAL PRACTIONER

Name: _____

Birth Date: **Year:**_____ **Month:** _____ **Day:** _____

Name of Parent/Guardian:_____

Sex: Male ☐ **Female** ☐

Mailing Address:_____

City: _____ **Postal Code**:_____ **Country:** _____

Home Phone: _____ **Mobile Phone:** _____

Fax: _____ **Email:** _____

2) HAVE YOU EVER HAD OR DO YOU SUFFER FROM

	No	Yes	(If yes, When)		No	Yes	(If yes, When)		No	Yes	(If yes, When)
Chicken Pox	☐	☐		Diabetes	☐	☐		Mental Illness	☐	☐	
Rubella	☐	☐		Tuberculosis	☐	☐		Eating Disorder	☐	☐	
Measles	☐	☐		Hepatitis A/B/C	☐	☐		Sleeping Disorder	☐	☐	
Mumps	☐	☐		Epilepsy	☐	☐					

3) PERSONAL MEDICAL HISTORY

Do you have allergies? (Specify)_____

Do you take medication on a regular basis? (Specify)_____

Do you have learning problems? (Specify) _____

Do you have any special dietary requirements? (Specify)_____

Have you ever had any accident with mental or physical impairment? _____

4) DECLARATION

I hereby certify that the above information is correct and that I agree to undergo a medical checkup if required to do so. I also declare that I will be responsible for the consequences of my eligibility to the applied course for giving false medical information.

Signature of applicant_____ Date:_____

Signature of the parent or legal guardian_____ Date:_____