Bolivar Technical College

MEDICAL INFORMATION

Student Name: ____ Date: ________________

Family Physician: ____ Phone: ______________

Emergency Contact Person: _________________________________ Phone: _______________

Indicate below if you have had any of the following:

Yes	No		Yes	No	
		Allergies			Hypertension
		Asthma			Kidney Infection
		Bronchitis			Nervous Trouble
		Cancer			Mental Disorder
		Contagious Diseases			Tuberculosis
		Chest Pain			Wear a Back Brace/Back Injury
		Diabetes			Artificial Limb
		Epilepsy			Hearing Loss
		Frequent Colds			Vision Loss (Not corrected by glasses)
		Heart Trouble			HIV
		Seizures			Allergy to bee or wasp
		Special Needs			Physical Disability

Other Please describe: ____

Surgeries: Yes No If yes, please describe: ______________________________

____

Are you currently taking any medications, vitamins or herbs: Yes No

If yes, please list: ____

____

Medication Allergies: Yes No If yes, please list: ______________________

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Medical Insurance: Yes No

Company ___________________________________ Policy # ______________________________

Do you bleed excessively after injury or tooth extraction? Yes No

Student Signature: ____