



Summer at St. George's INTERNATIONAL SCHOOL

2006 MEDICAL HISTORY FORM

Please note that the information contained herein is considered confidential and will only be shared with the Assistant Director and medical personnel in the event of a medical emergency. No person shall be denied entry based on the following information.

DATE: _____

PARTICIPANT'S NAME: _____

ADDRESS: _____ APT# _____

CITY: _____ COUNTRY: _____

HOME PHONE: _____ BUS. PHONE: _____

PARTICIPANT'S BIRTHDATE (DD/MM/YEAR): _____

DOCTOR'S NAME: _____ DOCTOR'S PHONE: _____

B.C. CARE CARD PERSONAL HEALTH NUMBER: _____

OTHER HEALTH/MEDICAL INSURANCE: _____ NUMBER: _____

Are you subject to any of the following:

- | | | | | |
|--|--|--|--|-------------------------------------|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ear Trouble | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Sleep Walking | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Motion Sickness | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Boils | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Frequent Colds | <input type="checkbox"/> Skin Disease | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Hysteria | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Nose Bleeds | <input type="checkbox"/> High Blood Pressure | | <input type="checkbox"/> Other _____ | |

Do you have any specific joint or bone problems? _____ Yes _____ No

If yes please explain: _____

Do you have any allergies?

____Foods Please Name _____

____Insect Stings Type _____

____Drugs Please Name _____

____Environment/hayfever Name Cause _____

____Skin Rash Name Cause _____

____Asthma 1. Stress induced _____ 2. Exercise Induced _____

