Student Health Assessment Form

STUDENT INFORMATION

Name (print last, first, middle) _____ Birth Date _____ Phone _____

Address _____ City _____ Province _____ Postal Code _____

PERSONAL HEALTH HISTORY – Please mark yes or no if you are receiving medical treatment presently or within the past 6 months

	Yes	No		Yes	No		Yes	No
Back Injuries	{ }	{ }	Heart Disease	{ }	{ }	Permanent limitation from		
Seizures, fainting, dizziness	{ }	{ }	Stomach Ulcer	{ }	{ }	illness, disease, or injury	{ }	{ }
Any type allergies	{ }	{ }	Skin Disease	{ }	{ }	Stomach, gall bladder trouble	{ }	{ }
Circulatory Disorder	{ }	{ }	Hearing difficulty	{ }	{ }	Nerve damage	{ }	{ }
Any type Hepatitis, jaundice	{ }	{ }	Kidney disease	{ }	{ }	Carpal tunnel	{ }	{ }
Nervous system disorder	{ }	{ }	Muscular disease	{ }	{ }	Previous broken bones/sprains	{ }	{ }
Respiratory disease	{ }	{ }	Cognitive disorder	{ }	{ }	Women-pregnant at this time	{ }	{ }
High Blood Pressure	{ }	{ }	Hernia	{ }	{ }	Joint Pain	{ }	{ }
Arthritis, gout, joint disease	{ }	{ }	Diabetes	{ }	{ }	Muscle Pain	{ }	{ }
Cancer	{ }	{ }	Headaches	{ }	{ }			

Will any of the above prevent you from starting or finishing the program? { } Yes { } No

If answer to any of the above is yes, please explain:

_____

_____

_____

_____

_____

_____

Medication Allergies _____

Would you say your present health is: { } Excellent { } Good { } Fair { } Poor

If you have marked yes in any part of the personal health history, VSOHA highly recommends that you consult with a physician <u>before</u> starting the program and by signing below you understand this recommendation.

Signature of Applicant _____