# St. Anthony's College

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## Student's Medical History

**PRIVATE & CONFIDENTIAL**

### Student Information

**Name (Surname, First Name)** _____ **Class:** _____

**Date of Birth (mm/dd/yyyy)** _____ **Student's Age:** _____

**Address (No Abbreviations):** _____

**In case of emergency contact:** _____ **Contact No:** _____

**Relationship of emergency contact to Student**:_____

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**Relationship of emergency contact to Student**:_____

### Student Medical History

Concussion or been knocked out? Yes ___ No ___ Fainting? Yes ___ No ___

Epilepsy, seizures, or fits? Yes ___ No ___ Heat Stroke? Yes ___ No ___

Hearing loss or deafness? Yes ___ No ___ Anemia? Yes ___ No ___

Heart trouble or murmurs? Yes ___ No ___ Diabetes? Yes ___ No ___

Uncontrollable coughing? Yes ___ No ___ Asthma? Yes ___ No ___

Back injury or frequent backaches? Yes ___ No ___ Kidney problems? Yes ___ No ___

Easy bruising or bleeding tendency? Yes ___ No ___ Bee sting allergy? Yes ___ No ___

Chest pain or faintness with exercise? Yes ___ No ___ Head or neck injury? Yes ___ No ___

Very bad vision in one or both eyes? Yes ___ No ___ High blood pressure? Yes ___ No ___

Do you wear glasses, contacts, other? Yes ___ No ___

Other allergies (food or medicine) Yes ___ No ___ If yes please specify:_____

Do you take any medicines? Yes ___ No ___ If yes please specify:_____

**Do you have a medical excluding your from playing sport?** Yes ___ No ___
(If yes, this document needs to be submitted to the school)

**Are there any other medical conditions that the school should be aware of?**

_____

_____

**Parent/Guardian Signature:** _____ **Date:** _____

**Parent/Guardian Name:** _____