PRESBYTERIAN SENIOR HIGH SCHOOL- BOMPATA

STUDENT MEDICAL FORM

NAME: ……

GENDER: MALE / FEMALE

DATE OF BIRTH: ….…….

MEDICAL HISTORY

1. Do you have any chronic medical conditions? (Yes / No)

   If yes, please specify. ……

   ……...

2. Have you had any serious illness or hospitalizations in the past? (Yes / No)

   If yes, please specify. ……

   ……...

3. Are you currently taking medications? (Yes / No)

   If yes, please specify. ……

   ……...

4. Do you have any emotional or developmental disabilities? (Yes / No)

   If yes, please specify. ……

   ……...

PARENT / GUARDIAN INFORMATION

NAME: …….

RELATIONSHIP: …….

CONTACT NUMBER: ……

SIGNATURE: …….. **DATE:** …….