



WESTMINSTER COLLEGE

Home Of The Diplomats

MEDICAL INFORMATION FORM

STUDENT'S MEDICAL RECORD

This form must be completed fully and accurately, and returned when the student enters school.

STUDENT ID# _____

ACADEMIC YEAR: 2010-2011

DOCTOR'S REPORT

PERSONAL INFORMATION

First Name: _____ Middle Name: _____ Family Name: _____

Date of Birth: Day _____ Month _____ Year _____ Age: _____ Sex: Male Female

Nationality: _____ Place of Birth: _____

I have examined the above student and give my report as follows:

HEIGHT	
HEARING	
WEIGHT	
TEETH	
VISION	

MISCELLANEOUS MEDICAL INFORMATION

1. Are you personally acquainted with the student's medical history? Yes No

2. List any known allergies, including drug sensitivities:

3. Is the student now receiving medication that you advise continuing? Yes _____ No _____ If yes, please list _____

4. Is there any reason that the student should be limited in a regular education program? Yes _____ No _____ If yes, explain _____

5. Has the student ever been restricted in a physical programme before or one that would prevent the student from following the school's academic and sports programme? Yes _____ No _____ If yes, why? _____

6. Are there any additional problems, which should be called to our attention? Yes _____ No _____ If yes, explain _____

7. Are the student's age-appropriate immunizations current? Yes _____ No _____

DOCTOR'S PROFESSIONAL INFORMATION

Doctor's Name: _____ Date of Examination _____

PLEASE PRINT

Doctor's (Postal/Street) Address: _____

Telephone contact: (Office) _____ Fax: _____ Emergency _____

Doctor's signature and stamp _____

**Please send this form directly to:
The Admissions Office**