"Excellence to the glory of God"

STUDENT MEDICAL INFORMATION FORM

Please complete this form carefully and accurately. The information provided is confidential and will only be used by authorized medical personnel in case of an emergency.

1. Studennt Personal Information

- Sex : □ Male □ Female
- Last Name: _____
- Last Name at birth (if différent): _____
- First Name(s): _____
- Date of Birth: _____ / _____ / _____
- Nationality: _____
- Address: _____
- Postal Code: _____ City _____
- Country: _____
- Telephone(s) : (1) _____ (2) _____
- Email: _____@ _____
- Other (specify) : _____

2. Contact in case of emergency

- Sex: □ Male □ Female
- Last Name and First Name(s): _____ _____
- Relationship: _____
- Telephone(s): (1) _____ (2) _____
- Email: _____@ _____
- Other (specify): _____
- Preferred method of communication: ☐ Telephone ☐ Email ☐ Other

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3. Medical History

Please tick the relevant boxes and provide details if necessary.

- Allergies:
  - **Medications:** □ Yes □ No
    If yes (specify):
  - **Food:** □ Yes □ No
    If yes (specify):
  - **Other (pollen, insect bites, etc.) :** □ Yes □ No
    If yes (specify):
- Chronic diseases:
  - Asthma: □ Yes □ No
  - Diabetes: □ Yes □ No
  - Epilepsy: □ Yes □ No
  - High Blood pressure: □ Yes □ No
  - Other (specify):
- Previous surgeries: □ Yes □ No
  If yes (specify) the date(s) and nature of the surgery :
  (1) ___ / ___ / _____ : _____ (2) ___ / ___ / _____ : _____
- Previous hospitalizations : □ Yes □ No
  If yes, please specify the date and reason:

4. Current Medications

- Are you currently taking any medication? □ Yes □ No
  If so, please list the medications, dosage, and frequency:

5. Vaccinations

- Please indicate the dates of your last vaccinations.
  - Tetanus:
  - Diphtheria:
  - Poliomyelitis:
  - Hepatitis B:

- Other (specify): (1) _____ : _____
  (2) _____ : _____
  (3) _____ : _____

6. General Information

- Blood Group:
- Do you wear glasses or contact lenses? □ Yes □ No
- Is there any other medical information that you consider important to share with the medical staff? (For example: dietary restrictions, special diet, specific needs, etc.):

  _____
  _____
  _____

7. Consent and Signature

I, the undersigned _____ _____, certify that all the information provided on this form is accurate and complete. I authorize the facility's medical staff to use this information in case of a medical emergency.

- Date: _____ / _____ / _____

- Student's signature: _____