Picture

Portmore Community College
Health Information Form

NB: The information on this form is confidential. Please return completed form in a sealed envelope marked "CONFIDENTIAL" and addressed to the College Nurse, Portmore Community College.

Section A (*to be completed by applicant*)

Instructions: Please complete accurately and in full.

GENERAL INFORMATION				
Surname		**Gender**		
		Male ☐ Female ☐		
First & Middle Names		**Date of Birth**		
		Day	*Month*	*Year*
Present Residential Address				
Telephone(s)	**Home**	**Office**	**Other**	**Other**
Programme/Department				

EMERGENCY CONTACT INFORMATION				
Next-of-Kin Name		**Relation**		
Address				
Telephone(s)	**Home**	**Office**	**Other**	**Other**

Section B (*to be completed by examining physician*)

Instructions: Please put a checkmark "√" and complete in full where applicable.
Note any additional comments on the blank side of this form and indicate with '

EXISTING MEDICAL CONDITION INFORMATION					
Asthma		Cancer		Diabetes	
Epilepsy		Heart Disease		Hypertension	
Mental Illness		Physical Handicap		Sickle Cell Disease	
State any allergies:					
State any other significant condition(s):					
State any existing drug therapy and reason for same:					

IMMUNIZATION INFORMATION					
Please provide verification that these are up-to-date. If no verification can be provided, physician should administer as necessary.					
Vaccine	√	***Date***	***Vaccine***	√	***Date***
MMR			Hepatitis B		
Diphtheria/Tetanus			Polio		
Tetanus Toxoid			BCG		
Varicella (Chicken Pox)			Mantoux/PPD *(state reading)*		

RECENT ILLNESS EVENT & THERAPY HISTORY *(LAST 5 YEARS)*			
Therapy / Hospitalization	**Date**	**Duration**	**Comments**

ROUTINE PHYSICAL EXAMINATION		
Blood Pressure	Height	Weight
Vision	Hearing	Chest X-Ray (***If indicated)***

LABORATORY EXAMINATION- Optional			
BLOOD (OPTIONAL)	Group (***Optional***)		Sickle Cell
	Haemoglobin		
URINE (***Routine office results accepted***)	Albumin		Glucose
STOOL (OPTIONAL)	Ova	Cyst	Blood

I certify that this applicant is in good health and able to undertake the programme of work/study.

Physician: _____ Signature: _____ Date:_____

I certify that I have been examined as required and that all the responses given are true and accurate.

Applicant: _____ Signature: _____ Date:_____