Zion Ministerial Institute
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ZION MINISTERIAL INSTITUTE

Student Health Form

Date: ______________________

Name of applicant: ____ Age: ________________
Last Middle First

Address: ____
Street & Number City Province Zip Code

HISTORY

Are you subject to the following:

- ❑Asthma
- ❑Allergy
- ❑Fainting Spells
- ❑Dizziness
- ❑Shortness of breath
- ❑Sore throats, cough
- ❑Constipation
- ❑Stomach disturbances
- ❑Gall bladder attacks
- ❑Loss of weight
- ❑Headaches
- ❑Other symptoms

Do you get tired easily? _______________ Do you wear glasses? ________________

Give the date of your last eye examination: ___________________________________

Do you require a special diet? _____ If yes, please explain more. ____________________________

Have you ever had the following:

- ❑Scarlet fever
- ❑Diptheria
- ❑Smallpox
- ❑Tuberculosis
- ❑Hepatitis
- ❑Measles
- ❑Mumps
- ❑Malaria
- ❑Epilepsy
- ❑Chicken pox
- ❑Whooping cough
- ❑Typhoid
- ❑Rheumatic fever
- ❑Diabetes
- ❑Amoeba or bacillary dysentery

Other illness

Has there been any recurrence of or complications resulting from above illness?__________________

If yes, explain ____

Have you had any surgeries? ____

Are you on any medication? ____

Do you need to keep taking any kind of medicine? ________________________________

While ZMI will try to help protect the safety and health of each student, I understand that ZMI is not responsible to ensure or to guarantee the safety and health of any student. I will be responsible to pay any medical bills that I may incur while a student at ZMI, and I release ZMI from any such claims.

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Applicant's Signature