PART I HEALTH HISTORY

ATTENTION APPLICANT: You must provide IMMUNIZATION RECORDS with this form.

Please include with your completed Health History form medical proof that you have received the following immunizations: DTaP, TD or Tetanus, Polio, Rubella (Measles), Mumps, Rubella (German Measles).

PLEASE PRINT – To be completed by the Applicant

Last Name:	First Name:		MI:
Current Address:		City:	
State/Province/Region:	Postal/Zip Code:	Country:	
Country of Citizenship:	Email:		
Age:	Birth Date: (mm/dd/yy)	Gender: □ Male □ Female	SSN: _____-_____-_____
Cell Phone:	Home Phone:		

In case of emergency, please notify:

Name:	Relation:	Phone:	
Address:	City:	State:	Zip Code:

Parent or Guardian:

Name:		Phone:	
Address:	City:	State:	Zip Code:

Family Physician:

Name:		Phone:	
Address:	City:	State:	Zip Code:

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1. Have you had a skin test for tuberculosis? ☐ Yes ☐ No	Dates administrated: (mm/dd/yy)	Results: ☐ Positive ☐ Negative
2. Have you been associated with a tuberculosis patient? ☐ Yes ☐ No	When? (mm/dd/yy)	
3. Are you allergic to any antibiotics or other medications? ☐ Yes ☐ No If yes, please specify:		
4. Are you presently under a medical doctor's care? ☐ Yes ☐ No If yes, for what?		
5. Are you taking prescription medications? ☐ Yes ☐ No If yes, what?		
6. Have you suffered a nervous breakdown? ☐ Yes ☐ No If yes, explain:		
7. Have you ever been under a doctor's care for an emotional disorder? ☐ Yes ☐ No What institution? If yes, explain:		

HISTORY OF DISEASES

Pleas mark any of the following that apply:

Past	Now		Past	Now		Past	Now	
☐	☐	Asthma	☐	☐	Chicken pox	☐	☐	Thyroid Disturbance
☐	☐	Hay Fever	☐	☐	Measles	☐	☐	Convulsions
☐	☐	Frequent Colds	☐	☐	Mumps	☐	☐	Palpitations of Heart
☐	☐	Persistent Cough	☐	☐	Tonsillitis	☐	☐	Shortness of Breath
☐	☐	Spitting of Blood	☐	☐	Rheumatic Fever	☐	☐	Swelling of Feet
☐	☐	Night Sweats	☐	☐	Diabetes	☐	☐	Back Trouble
☐	☐	Eye Trouble	☐	☐	Epilepsy	☐	☐	Frequent headaches
☐	☐	Ear Trouble	☐	☐	Stomach Ulcer	☐	☐	Insomnia
☐	☐	Nasal Obstruction	☐	☐	Tuberculosis	☐	☐	Nervousness
☐	☐	Fainting or Dizzy Spells	☐	☐	HIV +/ AIDS	☐	☐	Frequent Urination
☐	☐	Skin Trouble	☐	☐	Rubella	☐	☐	Joint Trouble
☐	☐	Constipation	☐	☐	Eating Disorder	☐	☐	Indigestion
☐	☐	Smallpox	☐	☐	Scarlet Fever	☐	☐	Typhoid Fever
☐	☐	Whooping Cough	☐	☐	Diphtheria	☐	☐	Pleurisy
☐	☐	Malaria	☐	☐	Appendicitis	☐	☐	Gonorrhea
☐	☐	Infantile Paralysis	☐	☐	Syphilis	☐	☐	Other Illness

AGREEMENT

I hereby agree that the information I have provided in this form is true. I further understand that if I have overlooked a question, or failed to complete any application form by CFNI standards that the review process of my application may be delayed, which might ultimately result in me having to wait until the following semester to attend. Health records will be held in strictest confidence as with all other materials submitted to CFNI. I have read this statement and thereby authorize CFNI administration to release necessary health information in emergency or life-threatening situations.

If applicant is under 18 years, he/she should have his/her parent or guardian agree below.

_____ _____

Applicant's Signature Parent/Guardian Signature