



STUDENT MEDICAL FORM

Experience Life International, Inc.

Instructions:

A visit with your doctor or medical clinic to obtain immunization history and record of past diseases is required of every applicant before a file will be reviewed by the Admissions Administrator.

Personal Information

Name _____
Family / Surname Given Name Middle In. Maiden

Gender: ___ Male ___ Female Date of Birth ___ / ___ / ___ Age _____
Day Month Year

Current Contact Information

Present Address _____

City _____ State/Province _____ Zip _____

Daytime Telephone (____) _____ Country _____

Nighttime Phone (____) _____ Mobile (____) _____

E-mail _____

Parent or Guardian:

Name _____ Telephone (____) _____

Address _____

City _____ State _____ Zip _____

Examining Physician:

Name _____ Telephone (____) _____

Address _____

City _____ State _____ Zip _____

History of Diseases

Please mark any of the following which apply:

Past	Now

Asthma
Hay fever
Frequent colds
Persistent cough

Past	Now

Thyroid disturbance
Convulsions
Palpitations of heart
Shortness of breath

Past	Now

Chicken Pox
Measles
Measles, German (Rubella)
Mumps

Past	Now

Smallpox
Whooping cough
Scarlet Fever
Typhoid fever

		Spitting of blood			Swelling of feet			Tonsillitis			Pleurisy
		Eye trouble			Frequent headaches			Rheumatic fever			Malaria
		Ear trouble			Insomnia			Diabetes			Infantile paralysis (polio)
		Nasal obstruction			Nervousness			Epilepsy/convulsions			Appendicitis
		Fainting or dizzy spells			Frequent urination			Stomach ulcer			Syphilis
		Skin trouble			Joint trouble			Tuberculosis			Gonorrhoea
		Constipation			Indigestion			HIV +/-AIDS			

Have you had a skin test for tuberculosis? Yes No
 Date Administered: _____ Results: Positive Negative

Have you been associated with a tuberculosis patient? Yes No

Are you allergic to any antibiotics or other medications? Yes No

Are you presently under a medical doctor's care? Yes No

Are you taking prescription medicines? Yes No If yes, what? _____

Have you suffered a nervous breakdown? Yes No If yes, please explain:

Have you ever been under a doctor's care for an emotional disorder?
 Yes No If yes, please explain: _____

Immunization Record

	Date	Date	Date	Date
DTP				
TD or Tetanus				
Polio				
Rubella (Measles)				
Mumps				
Rubella (German Measles)				
Hepatitis-B				
Meningitis Vaccine				

Health records will be held in strict confidence as with all other materials submitted in application with ELI 360. The applicant is to sign below that he/she has read this statement and thereby authorizes ELI 360 administration to release necessary health information to the institutions of application. (If applicant is under 18 years, he/she must have his/her parent or guardian co-sign.)

 Applicant's signature Date _____

 Parent/Guardian's signature Date _____

 Physician's signature Date _____