OVERSEAS THEOLOGICAL SEMINARY
Student Health History
海外神學院
學生健康資料

1. Name of applicant: _____, _____
Last Name First Name Middle Name Chinese Name

2. Name of physician: _____, _____
Last Name First Name Middle Name Chinese Name

3. Address of physician: _____

_____

Phone #: _____ **E-mail address:** _____

4. Does the applicant have or have had any of the following?

	Yes	No		Yes	No
Tuberculosis	☐	☐	Epilepsy	☐	☐
Heart Trouble	☐	☐	Paralysis	☐	☐
Fainting Spells	☐	☐	Diabetes	☐	☐
Nervous Breakdown	☐	☐	Convulsion	☐	☐
Abnormal Blood Pressure	☐	☐			

5. Has he/she ever changed or advised to change his/her residence or occupation because of health reason? ☐ Yes ☐ No

6. Has he/she ever received treatment or has treatment been recommended by a physician for physical or emotional condition? ☐ Yes ☐ No

7. Any continuing health problem? ☐ Yes ☐ No

If yes, what is it? _____

9. Does the applicant have any other disability which affects class attendance (such as vision, hearing, or walking disability)?

_____

_____

Physician's Signature: _____ **Date:** _____

(6.13.2012)