

Compulsory Health Form

It is mandatory to submit a completed health form with your application.
This health form must be signed by a Physician with their official stamp.

Today's Date _____ Course start date _____ Length of course _____

Student's Name _____ Date of Birth _____

Male Female

Parent's Name _____

Phone Number _____

In Case of Emergency Notify _____

Phone Number and Email _____

Relationship to Student _____

Medical History

Please list any medical conditions you have: may include asthma, allergies, diabetes, heart conditions, high or low blood pressure etc.

List all medications that you take. Please include birth control pills, vitamins and minerals. We recommend that you bring what you may need or a written prescription from your physician.

Non-prescription _____

Prescription _____

List any allergies or reactions you have had to medications.

Medication	Reaction	Date
_____	_____	_____
_____	_____	_____

Do you smoke? Yes No

List any allergies or reactions you have to foods, molds, pollens, bees, insects, animals etc.

List any physical or dance related problems you have including injuries, bone, joint, or muscular disorders, etc.

Have you ever been hospitalized? Yes (If yes, please specify below including dates) No

Physical illness _____

Injury _____

Surgery _____

Psychiatric _____

Have you been diagnosed with mental health issues, severe stress, mood change, or personality disorder BDC should be aware of?

Have you been vaccinated for the following: Chicken Pox Measles Mumps

Please list all doctors' information below, including primary care physician, chiropractors, physical therapists, etc.

Primary Physician _____ Telephone _____

Other Health Care Providers _____ Telephone _____

Student Declaration

I, _____, confirm that the information provided on this form is correct and true.

Student's signature _____ Date _____

Doctor's statement

I, _____ confirm that _____ is physically and mentally fit to participate in 18 hours of dance per week whilst studying at Broadway Dance Center. I confirm that the above information listed in this health form is true and correct.

Doctor's Signature (required)

Date

Doctor's official stamp

Doctor's Address

Telephone number

Email