

## 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.

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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.

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

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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?

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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