PACIFIC TORAH INSTITUTE
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MEDICAL HISTORY

Please print carefully and legibly.

For Admission in Sept. _____ Entering Grade ___ Dormitory___ Non-Dormitory__

Name of Student_____Date of Birth _____Mth/Day/Year

Home Address _____ Home Phone _____

City_____State/Province _____ Zip Code/Postal Code_____

Father's First & Last Name _____Work _____Mobile _____

Mother's First & Last Name _____Work _____Mobile _____

1st Emergency Contact: _____Relation to Student _____

Home _____Work _____Mobile _____

1st Emergency Contact: _____Relation to Student _____

Home _____Work _____ Mobile _____

BC Medical # _____

Primary Care Provider Name _____Phone _____

Specialist's Name _____Phone _____

Please list any existing medical conditions: _____

_____

Please list any medical conditions from the last three years: _____

_____

Please list any medication that your child is currently taking, and indicate the reason, daily schedule, dosage, and if he will be self-administering, or if he needs assistance:

Medication	**Reason**	**Daily Schedule/Dosage**	**Self-Administering?** **Y or N**

Please describe any other health concerns or issues that you feel the Yeshiva should be aware of: phobias, severe shyness, etc. _____

_____

I hereby certify that the information given in this form is complete and accurate.

_____	_____	_____
Parent's Name	Signature of Parent	Date