

# CATHERINE HINDS INSTITUTE

## STUDENT HEALTH FORM Part A (To be completed by student)

Name \_\_\_\_\_

Last

First

Middle

Date of Birth \_\_\_\_\_

Mo/Day/Yr

Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Student's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

Physician's or Health Care Provider's Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip Code \_\_\_\_\_ Telephone \_\_\_\_\_

### Part B (To be completed by Physician or Health Care Provider)

1. Does the student have any medical conditions that will affect their performance at The Institute? If yes, please list/describe. \_\_\_\_\_

\_\_\_\_\_

2. Is the student currently on any medication? If yes, please list/describe as well as potential side effects.

\_\_\_\_\_

3. Has the student ever been on Accutane or its generic form?

\_\_\_\_\_

4. Has the student been on any of the following topical skin medications in the last 3 months? **(Circle all that apply) Clindamycin Dalbavancin Vancomycin Retinol Erythromycin**

5. Will any of the above medications prevent the student from receiving facials, face and body waxing, peels or laser treatments of any kind? \_\_\_\_\_

\_\_\_\_\_

6. Is the student under treatment for any medical or emotional conditions (including allergies)? If yes, please list/describe. \_\_\_\_\_

\_\_\_\_\_

7. Check whichever applies:

\_\_\_ Student has no communicable disease

\_\_\_ Student has a communicable disease Please explain \_\_\_\_\_

**Physician's or Health Care Provider's**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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