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_____