كلية فاطمة للعلوم الصحية
FATIMA COLLEGE OF HEALTH SCIENCES

Student Health Fitness Form

Photograph

* To provide the best health emergency care, please fill out this form with complete precision

Student's Name: ..... **Nationality:** .....
Student's ID: ..... **Mobile:** .....
Date of Birth: ..... **Gender:** ☐ Male ☐ Female

Guardian address:

Mobile: ..... **Home Number:** .....
City: ..... **Region:** .....
Email: .....

The student's medical history:

*Do you suffer from any of the diseases listed below? If the answer is "yes", please provide details such as diagnosis and treatment.
*For allergy, please specify the type of sensitivity and intensity

Health Problems	Details	Yes	No
H.I.V		☐	☐
Hemoglobin		☐	☐
G6PD		☐	☐
Thalassemia		☐	☐
Sickle Cell Anemia		☐	☐
Allergies		☐	☐
Asthma		☐	☐
Neurological diseases		☐	☐
Seizure disorder/ Epilepsy		☐	☐
Diabetes		☐	☐
Frequent infections		☐	☐
Hearing difficulties		☐	☐
Frequent headaches		☐	☐
Heart conditions		☐	☐
Glasses/ contact lenses		☐	☐
Emotional/ mental disorders		☐	☐
Other health problems		☐	☐
Any previous hospitalization		☐	☐

*Please describe any physical or psychological illness you have been suffering from previously or currently.

.....

.....

.....

*Are you taking medicines regularly or intermittently, please mention the name of the medication and dosage.

Dosage	Medicine's Name

*Doctor's name, clinic or medical center

Health Insurance: ..... **Phone Number:** ..... **Clinic / Hospital**

Doctor's Name: .....
Stamp: .....

Student and Guardian Signature

Student's Name: ..... **Date** ..... **Signature:** .....
Guardian's Name: ..... **Date** ..... **Signature:** .....