



TASIS LES TAPIES PROGRAM 2024

CONFIDENTIAL MEDICAL HISTORY

STUDENT APPLICANT:

Last Name: _____ First Name: _____
Date of Birth: _____ Day _____ Month _____ Year _____ Gender: Male Female

TO BE COMPLETED BY PARENT/GUARDIAN

1. Please tick any contagious diseases the student has had or against which he or she has been vaccinated:

Mumps Whooping Cough
Measles Chickenpox
German Measles (Rubella) Other (please specify) _____

2. Does the student suffer from any allergies? Yes No

3. Is he or she allergic to any drugs? Yes No

If yes, state names: _____

Please send any emergency medication for Severe Reactions (bee sting kits, inhalers, etc.)

4. Please indicate the dates when the following were last given:

Polio vaccination _____

Tetanus vaccination _____

5. Is the student currently receiving any prescribed medicines that he or she should continue to take during the program?

Yes No

If yes, please specify the disorder, name of medication, and dosage:

6. Please state whether there are any existing conditions, physical or psychological, which limit his or her activities

Yes No

If yes, please specify (please use a separate sheet of paper if necessary):

7. Is the student a Vegetarian? Yes No

8. Does the student have any other dietary requirements? Yes No

If yes, please specify:

Signature of Parent/Guardian

Date