MEDICAL HISTORY (PART OF THE APPLICATION FORM)

To be completed by ALL applicants:

Name:__________________________________ Date of Birth: ______________________

Full address: ____

____

Parent(s) or Legal Guardian(s) name(s): ____

Family physician name: ____

Address: ____

____

Have you ever suffered or received treatment for a mental or nervous disorder? If your answer is yes, please explain on a separate piece of paper.

Please underline any of the following conditions that affect you:

Diabetes *Epilepsy* *Asthma/ Hay Fever* *Fainting Spells* *Headaches/Migraines*

List any allergies you have: ____

____

List any medications you take on a regular basis:____________________________________

____

Do you have any doctor-recommended diet concerns? If yes, please provide details:

____

____

Please mail this form to:
FaithWay Baptist College of Canada
Director of Admissions
1964 Salem Road
Ajax, ON L1T 4V3
or email: info@fbccanada.org