

# Confidential Medical Record

## PART I General Information (To be completed by the applicant)

FOLLOW-UP
APPROVAL

1. Name \_\_\_\_\_

2. Program Name \_\_\_\_\_ 3. Program Starting Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

4. Occupation \_\_\_\_\_ 5. Birthdate \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ 6. Age at program start \_\_\_\_\_

7. Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs. 8. Male \_\_\_\_\_ Female \_\_\_\_\_ 9. Daytime Phone (\_\_\_\_) \_\_\_\_\_

10. Address \_\_\_\_\_ Evening Phone (\_\_\_\_) \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

11. Family Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_ 12. Soc. Sec. # \_\_\_\_\_

13. In case of emergency contact \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Daytime Phone (\_\_\_\_) \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Evening Phone (\_\_\_\_) \_\_\_\_\_

14. Father/Guardian \_\_\_\_\_ Mother/Guardian \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Employer \_\_\_\_\_ Employer \_\_\_\_\_

Title/Occupation \_\_\_\_\_ Title/Occupation \_\_\_\_\_

Telephone (Home) (\_\_\_\_) \_\_\_\_\_ Telephone (Home) (\_\_\_\_) \_\_\_\_\_

Telephone (Work)(\_\_\_\_) \_\_\_\_\_ Telephone (Work) (\_\_\_\_) \_\_\_\_\_

15. Do you speak and understand English? Yes  No

16. Ethnic Background (optional)  Asian  Black / African American  Hispanic

Native / American Indian  White / Caucasian  Other \_\_\_\_\_

Please Note: Each applicant is responsible for any medical expenses and should be covered by his/her own sickness and accident insurance. (The following questions must be answered for our insurance records.)

17. Is applicant covered by any hospitalization/medical care policy? Yes  No

18. Insurance Company Name \_\_\_\_\_ Policy or Certificate # \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

19. Does insurance company require pre-authorization? Yes  No  If yes, phone (\_\_\_\_) \_\_\_\_\_

**Signature Required**

Consent is hereby given for the applicant to attend the above named program and permission is given for any emergency anesthesia, operation, hospitalization or other treatment which might become necessary.

All information will remain confidential. You should know that over the years, many applicants with a variety of medical/psychological difficulties have successfully completed our programs, but we must be aware of these conditions. Failure to disclose such information could result in serious harm to you and your fellow applicants.

If you arrive at the program start with a pre-existing condition or injury which is not indicated on your medical form and you are subsequently forced to leave the program because of that condition, you will be charged an evacuation fee and will not receive a refund.

\_\_\_\_\_  
Parent / Guardian (if applicant is under legal age) Date \_\_\_\_\_

\_\_\_\_\_  
Applicant's Signature Date \_\_\_\_\_





