THE AMERICAN INSTITUTE OF MANAGEMENT SCIENCE INC

101 NE Third Avenue, Suite 1500,
Fort Lauderdale, FL 33301
CALL THE US TOLL FREE:
1-800-981-2810 / 786-923-1480
876-754-7822

Medical History Form

This form is to be filled out completely by the applicant and a Physician and returned to the Admissions office. This information is confidential and will be kept on file. The information herein will be used only in case of an emergency or medical situation.

STUDENT:

Date: _____ Student ID: _____

Student Full Name: _____

Campus: _____ Semester: _____

Home Address: _____

Email Address: _____

Phone: ( ) _____ Birth date: _____

IN CASE OF EMERGENCY NOTIFY:

Name: _____ Relationship: _____

Phone: _____ Email: _____

Address: _____

PSYSICIAN:

Physician Name: _____ Physician's ph. #:_____

Phone:_____ Email: _____

Address: _____

PHYSICIAN SIGNATURE:_____ DATE:_____

STATEMENT BY STUDENT (OR PARENT/GUARDIAN IF STUDENT IS UNDER THE AGE OF 18)

I understand that in case of any emergency requiring medical treatment, every effort will be made to reach one of the next of kin listed above. If he/she cannot be contacted, I authorize the school to give consent to treatment as deemed necessary by emergency responders. I also consent to accept all fees incurred in provide transportation and career where any is incurred.

Name of Guardian/s: _____ Signature of Guardian/s: _____ Date: _____

Applicant Self-Disclosure of Medical History and Information to review with your Physician before sending to AIM

To the applicant: please circle Yes or No for each item. Each question must be answered.

GENERAL MEDICAL HISTORY

Do you currently have or have you had a history of:

Respiratory problems? (e.g., asthma) 1. Yes No

Gastrointestinal conditions? (e.g., heartburn) 2. Yes No 3. Diabetes?

3. Yes No

Specific comments:

_____

_____

Hypertension? 4. Yes No

Bleeding or blood disorders? 5. Yes No

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Hepatitis or other liver disease? 6. Yes No

Specific comments:

_____

_____

Neurological problems? (e.g., seizure disorder) 7. Yes No

Dizziness or fainting episodes? 8. Yes No 9.

Cardiac problems? 9. Yes No

Specific comments:

_____

_____

Disorders of the urinary or reproductive tract? 10. Yes No

Any other medical conditions or considerations that may affect your participation (including loss of hearing or vision)? 11. Yes No

Specific comments: _____

Do you see a Medical or Physical specialist of any kind? 12. Yes No

Physician Name_____

Address _____

Are you pregnant? 13. Yes No

Specific comments:

_____

PERSONAL HISTORY (COUNSELLING/PSYCHIATRIC)

Have you had treatment or counseling with a mental health professional? 14. Yes No

Are you currently in treatment or counseling? 15. Yes No

Name and address of therapist

_____

Hospitalization within the past year? 16. Yes No

Reasons for treatment or counseling?

____suicide gesture ____academic/career

____substance abuse/chemical dependency ____family issues/divorce

____eating disorder (anorexia/bulimia) ____learning disability

____other (please give specifics below)

Specific comments:

_____

_____

ALLERGIES

Any environmental allergies? _____ 17. Yes No

Is iodine contraindicated for you? 18. Yes No

Are you allergic to any foods? Do you have any dietary restrictions? 19. Yes No

_____

Allergies to insect bites or bee stings? 20. Yes No

Specific comments: _____

Date of Last Tetanus Immunization? _____

MEDICATIONS

Are you allergic to any medications?_____ 21. Yes No

Are you currently taking any medications? Please specify dose. 22. Yes No

Medication Dosage (amt./freq.) Side Effects/Restrictions

_____

_____

History of heat stroke or other heat related illness? 23. Yes No

Specific comments:

_____

_____

FITNESS

Do you exercise regularly? 24. Yes No

Intensity Level

Activity Frequency Duration/Distance Easy Moderate Competitive

_____

_____

Do you smoke? If so, how much?_____ 25. Yes No

Are you in an appropriate weight range for your height? 26. Yes No

Swimming Ability (check one): ____non-swimmer ____recreational ____competitive

Physician Physical Examination

To be completed by the Physician only: **Sign and use Medical Practice Stamp to authenticate**

Applicant/Patient's Name: _____

Height: _____ Weight: _____

Blood Pressure:_____ Pulse:_____

Cardio-respiratory exam _____

Have you reviewed the applicant's Medical History Form (4 pages)? Yes ___ No ___

Please comment on specific areas from the Medical History Form that need elaboration.

_____

_____

_____

Based on the information provided in the Medical History Form, their medical history self-disclosure and the physical examination, do you feel that this individual can participate in these Programs?

____ YES, I think this person can participate

____ MAYBE, if the following restrictions or concerns can be accommodated in the program

____ NO, this person should not participate at this time for the reasons below

Comments (reasons, restrictions, or concerns):

_____

_____

_____

Examiner's Name: _____

Phone: _____ Email: _____

Address: _____

PHYSICIAN SIGNATURE: _____ DATE: _____

Please return all original pages (including pages 1-5 of the Medical Form) to:

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