



STEINBACH BIBLE COLLEGE

Medical Information

Name _____, Birthday (mm/dd/yy): _____

Provincial Family Medical # _____, Provincial Personal Medical # _____

In which Canadian province do you have medical insurance/coverage _____ Note: International students must provide confirmation of comparable coverage or purchase medical insurance through the SBC Business office.

Person to be notified in case of emergency _____ Relationship _____

Phone # (____) _____ alt # (work or cell) (____) _____

Do you have any known allergies (medications, foods, other)?* _____ If yes, please explain as specifically as possible

Do you have any physical, mental or learning disabilities?*** _____ If yes, please explain _____

Please list any medical conditions or diseases you have (eg diabetes, epilepsy, asthma, migraines) _____

Please list any communicable diseases you have or have had (eg HIV, infectious mononucleosis, hepatitis, TB)

Have you ever had any mental health issues? _____ If yes, please complete the following Depression Eating Disorders Addictions Suicidal Intent Panic/Anxiety Disorders Other _____

Are you currently under treatment for these (or any other) medical condition(s) _____

Are you currently using any prescription or over the counter medications? _____ If yes, please identify the medication and note any side effects _____

Have you ever used drugs non-medically? _____ If yes, please complete the following

tobacco Date of last usage _____ Frequency of use (daily, weekly, monthly) _____

illegal drugs Date of last usage _____ Frequency of use (daily, weekly, monthly) _____

alcohol Date of last usage _____ Frequency of use (daily, weekly, monthly) _____

other _____

Please include any history, treatment, and the current situation of all of the above on the reverse side of this form. Also clearly indicate any accommodations we can make to enhance your experience at Steinbach Bible College.

The above Medical Information is being collected so that SBC may better address your medical needs and any dietary concerns you may have. This information may be shared among SBC faculty for administrative purposes to support your learning experience. In the event of an emergency medical situation, SBC will disclose this information *only to health care providers* for your assistance. This information will be stored in a secure and controlled manner.

The collection of this information does not in any way make SBC responsible or liable for monitoring your diet or medical condition, or suggest that SBC has the facilities to address your individual needs. The collection of this information makes it possible for SBC to provide information in emergency situations and to provide you with the most valuable experience possible while studying on our campus.

*Food Services will be informed of all food allergies, but also require a note from your doctor.

** Registrar will be made known of any mental or learning disabilities.

By signing below, I acknowledge that I am 18 years of age or older and that I consent to the collection, use, and disclosure of my medical information as outlined above.

Dated this day ____ of _____, 20____.

Student Signature (if under 18, the parent/guardian signature & Print Name)

I wish to discuss the possible use or disclosure of the preceding medical information with Student Development.