HEALTH RECORD

To be completed by student.
Keep a copy of this completed form.

STRICTLY CONFIDENTIAL

Revised August 2007

222 St. Patrick Street, Toronto, Ontario M5T 1V4 Phone: (416) 596-3101 Ext. 3320 Confidential Fax: (416) 596-7214 Email: healthservices@michener.ca

The information on this form is confidential and is intended for The Michener Institute and its clinical site(s).

Program____________________ **Graduating Year**________________

❑ Full-time Studies ❑ International Studies ❑ Distance Education

❑ Part-time Studies ❑ Continuing Education ❑ Access & Options

Last Name____

Given Names______________________________ Gender ❑ M ❑ F

Date of Birth____/____/____ Phone Number (current) (____)____________________

Email Address____

Permanent Home Address__________________________________

City/Prov.____________________________ Postal Code______________

Present Address (if different from above)__________________________

________________________________ Postal Code______________

OHIP Number____

Version Code__________________________ Expiry Date________________

I am not Covered in Ontario ❑

Name of any other health insurance provider________________________

Social Insurance Number______________________ (WSIB purposes)

Notify in Emergency______________________________________

Phone Number (____)____________________________________

Address____

Name of Family Physician or Clinic______________________________

Address____

Phone Number (____)______________________ Postal Code______________

What is the state of your general health?__________________________

____

Are you under medical care or observation now? ❑ No ❑ Yes

If yes please explain______________________________________

____

Please list all medical illnesses, stating years, which have necessitated medical attention including all communicable diseases and surgery.

____

____

____

Special Needs (e.g. mobility/physical problems, health and medical concerns)

____

____

What medications are you now taking?

____

Known Allergies

❑ No ❑ Yes ❑ Indicate if life threatening

Medication____

Environmental____

Food____

Latex____

History of:

Do you take allergy injections? ❑ No ❑ Yes

Hayfever____

Asthma____

Dermatitis____

Significant Immediate Family History

Cancer______________________ Heart Disease__________________

Diabetes_____________________ High Blood Pressure______________

Other____

Lifestyle History

Smoking____________________ Recreational Interests______________

Alcohol_____________________ Regular Exercise_________________

Sleep Pattern________________ Hearing Loss____________________

Dental Care__________________ Recent Weight Loss/Gain_____________

Vision Care - Glasses, Contact Lenses___________________________

Other____

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You are required to have a baseline TWO STEP TB Test. *See TWO STEP TB Test Info Sheet

Give place ____________________

1. Date__________ Result__________
2. Date__________ Result__________

Annual Tuberculin Tests: 1. Date__________ Result__________
2. Date__________ Result__________

Have you had a BCG Vaccination for T.B.? ☐ No ☐ Yes

Date__________ *(Students born in Quebec or outside Canada)*

Have you had a chest X-ray? ☐ No ☐ Yes

If yes give place____________________

1. Date__________ Result__________
2. Date__________ Result__________

(A chest x-ray is not required if TB test is negative)

Immunization Blood Test Date/s____________________

Test(s) Required____________________

IMMUNIZATION	DATE LAST RECEIVED OR DATE YOU HAD DISEASE	IMMUNITY
Heptatitis B* (1)		
(Engerix B) (2)		
(3)		
Measles*		
Mumps*		
Rubella*		
Chickenpox/Shingles/Varicella*		
**Immunity blood test required.*		
Polio		
Tetanus Toxoid		
Diptheria		
Td of TdP booster injection required every 10 years.		

To the best of my knowledge the above information is correct. I understand that misstatement is grounds for cancellation of admission. I give permission for Health Services to contact my family physician for information, and to release health information to my clinical site(s). I understand The Michener Institute has the right to cancel my admission privilege on the basis of medical information submitted or withheld.

I understand that it is my responsibility to inform the appropriate Michener personnel of any communicable disease, special need or medical condiition which may place me at risk or pose a risk to others at The Michener Institute or on placement.

Applicant's signature____________________ Date__________

Please complete ALL information requested and return this form immediately to:

The Michener Institute,
Attn: Health Services,
222 St. Patrick Street,
Toronto, ON M5T 1V4
or fax to: (416) 596-7214

If we do not receive your information, or if information is not completed, you will not be permitted to participate in the work placement component of your program.

KEEP A COPY of this completed form for your own records as you will require this information continually throughout your program for your work placement and future employer. A $10 processing fee will be charged to reproduce this information.

Freedom of Information and Protection of Privacy Act, 2003.
The information on this form is collected under the legal authority of the Colleges and Universities Act, P.S.O. 1980, C272, sS; Regulated Health Professions Act, 1991, s36(1) for use by Health Centre Staff. This information is used for administrative purposes.