

Victory Bible Colleges International



Confidential Health Form

Complete fully and mail to: Box 65077 North Hill P.O. Calgary, AB, T2N 4T6
Phone: (403) 286-8337, Fax: (403) 286-8335

****Not required for correspondence Students**

Name of Applicant _____

Address _____

City

Prov./ State

Zip code

Telephone # (____) _____ Birth date _____
(mm/dd/yy)

Canadian Students. Provincial Health Number _____ Province of Coverage _____

Do you have any additional health care coverage? Yes No

If Yes, please explain _____

International Students. It is **your** responsibility to obtain medical insurance while you are studying at Victory Bible Colleges International (VBCI). You will need to provide proof of coverage to the Registrar's office upon or before your arrival, if accepted to VBCI on-campus studies.

Person to Contact In Case of an Emergency:

Name _____ Telephone # _____

Address _____

Relationship _____

Personal History:

Do you wear contact lenses or glasses? Yes No Both

Are you presently taking medication? Yes No

If Yes, state what kind of medication, and how long you will be taking this medication.

Do you have any food or drug allergies? Yes No

If Yes, Please List _____

Have you ever received treatment for a mental, emotional or nervous disorder? Yes No

If yes, please explain. _____

Do you have any physical handicaps? Yes No

If yes, please explain. _____

Do you have any dignosed learning disabilities? Yes No

If yes, please explain. _____

Please Check if you have or had any of the following conditions:

- | | | |
|------------------------------------------------|----------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Skin Condition | <input type="checkbox"/> Eye Trouble | <input type="checkbox"/> Ear Trouble |
| <input type="checkbox"/> Head Injury | <input type="checkbox"/> Recurrent Headaches | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepititis | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Back Problems |
| <input type="checkbox"/> Dislocation of Joints | <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Gall Bladder Problems | <input type="checkbox"/> Intestinal Trouble | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Tumor/Cancer | <input type="checkbox"/> Anemia | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Measles | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Other _____ | | |

If other, please specify on a separate piece of paper.

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For more information please contact the Registrar's office:

Phone: (403) 286-8337 ext. 208

E-mail: info@vbci.org

Website: www.vbci.org