



# British West Indies Collegiate

*www.bwic.tc*

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## STUDENT MEDICAL FORM

Student's Full Name:

1. Does the above named student have any history of illness, such as Diabetes, Epilepsy, Asthma, Urinary infection, etc?

YES

NO

If YES, Please provide details below.

2. Is the above named student receiving regular medication?

YES

NO

If YES, Please provide details below.

3. To your knowledge, does the above named student have any allergies, such as those to food or medication?

YES

NO

If YES, Please provide details below.

### Contact Details of the Student's Physician

Name	Address	Telephone
<input type="text"/>	<input type="text"/>	<input type="text"/>

### Student's Medical Insurance Details

Company Name	Address	Telephone
<input type="text"/>	<input type="text"/>	<input type="text"/>

Signature of Parent/Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Name of above Signatory: \_\_\_\_\_

\* All above information will remain secure and confidential, and will only be used for the welfare of the student.