

Sheridan Health Registration Form

FOR OFFICE USE ONLY

Health Insurance or Out of Province Number _____

Version Code: _____ (letters, bottom right hand corner) Expiry Date: _____

Your Name (exactly as printed on card): _____

Address of Subscriber if out of Province: _____

The information you provide is **confidential**. It is intended for use by Sheridan Health Centre staff only in the event that you require our services. This information will **not** be released to anyone outside the Health Centre without your written permission.

Allergies:

Name: _____
Last First

Date of Birth: _____ / _____ / _____ Gender: M F
year month day

Student Number: _____ Program Name: _____

Currently in Year: 1 2 3 4 5 6 Program Length: _____ (# of years)

Campus: Trafalgar Davis Email: _____

Address (During College Year): _____

City: _____ Postal Code: _____

Phone: () _____ Cell: () _____

Notify in Emergency: _____ Relationship _____

Address: _____ Phone: () _____

City: _____ Postal Code: _____

Family Physician: _____

Address: _____

City: _____ Postal Code: _____

Phone: () _____ Fax: () _____

Please Turn Over →

Health Centre

Present or Past Illness(es) (Chronic illness or condition)	Yes ✓	No x	Comments
Diabetes			
Epilepsy			
Asthma			
Heart Disease			
High Blood Pressure			
Headaches			
Cancer			
Other			
History of:			
• Muscle/Bone Injuries			
• Emotional Stress Problems			
• Infectious Disease (e.g. Hepatitis B)			
• Weight Loss or Gain			
• Hospitalizations			

Special Needs (e.g., mobility, physical problems, health concerns): _____

Immunization TD (Tetanus, Diphtheria) Required every 10 years. Date: _____
Year only

Primary Series Polio with Reinforcing Booster? Yes No

Allergies? Yes No

If yes, please list and indicate which (if any) are life threatening and require an epi-pen.

Do you take any medication (Please list each drug by name including drugs for birth control, diabetes, epilepsy, blood pressure, etc.): _____

Student's Signature: _____ Date: _____