**HEALTH DISCLOSURE STATEMENT:** For the protection of your safety and the well being of all the students at the Kanakuk Institute, FULL disclosure must be made regarding any PHYSICAL, SOCIAL, AND/OR PSYCHOLOGICAL CONDITIONS. Failure to do so may result in your discharge from the program and the forfeiture of your tuition. Disclosure of health history is crucial to our ability to provide a supportive, safe and healthy learning environment for you. Please make a copy of this form and keep for your records.

### ALLERGIES:

- [ ] I am allergic to peanuts and/or nuts*  
  Explain: ____________________________________________

- [ ] I am allergic to these substances (mold, dust, insect stings, etc.)  
  __________________________________________________

- [ ] I am allergic to the following drugs:______________  
  __________________________________________________

### CHRONIC CONCERNS:

- [ ] Anorexia, Bulimia* (Eating Disorders)  
  Explain: ____________________________________________

- [ ] Anxiety__________________________________________

- [ ] As Berger’s/Downs/Autistic__________

- [ ] Asthma (even if only occasionally uses an inhaler)  
  Explain: ____________________________________________

- [ ] Bi-polar/Psycho/Social Disorder__________

- [ ] Bleeding Disorder________________________________

- [ ] Celiac Disease____________________________________

- [ ] Depression_______________________________________

- [ ] Diabetes*  
  Explain: ____________________________________________  
  Year Diagnosed:__________ Pump (Yes or No)__________

- [ ] Eczema___________________________________________

- [ ] Hearing/Visually Impaired___________________________

- [ ] Knee Problems (total knee replacement, ACL, etc.)  
  Year_________________________________

- [ ] Muscular/Coordination_______________________________

- [ ] Oppositional Behavior Disorder

### MEDICATION:

- [ ] Special Diet*  
  Explain: ____________________________________________

- [ ] Seizure disorder___________________________________

- [ ] Suicidal Tendencies__________________________

- [ ] Tourettes Syndrome__________________________

**MEDICATION:** Provide complete information.

- [ ] I do not take any medications on a regular basis.

1. Name of medication ____________________________
   
   Reason for taking ____________________________
   
   Dose taken ____________________________
   
   When taken each day ____________________________

2. Name of medication ____________________________
   
   Reason for taking ____________________________
   
   Dose taken ____________________________
   
   When taken each day ____________________________
Please note this information will be made available ONLY to those who will be working directly with your care. This information is to help us assist you in having the very best experience possible!

List and discuss any special needs you may have as well as other physical or psychological conditions (other than those noted on the Health Form):

________________________________________________________________________________________________________________________________________________________

Are there any special concerns you have regarding your year at the Institute?

________________________________________________________________________________________________________________________________________________________

Are there any pre-existing conditions that you have that may hinder your ability to take part in athletic activities at the Institute?

________________________________________________________________________________________________________________________________________________________

Is there any medical condition that you have that you would want to ensure that we were aware of?

________________________________________________________________________________________________________________________________________________________

If there is any additional information that you feel might be helpful, please attach a card or letter to this form.

________________________________________________________________________________________________________________________________________________________

Have you been hospitalized or had surgery for anything in the past 2 years; please be specific

________________________________________________________________________________________________________________________________________________________

Have you ever had or been treated by a Doctor for any of the following conditions:

<table>
<thead>
<tr>
<th>Please indicate with a check mark what you have been treated for</th>
<th>Y</th>
<th>E</th>
<th>S</th>
<th>N</th>
<th>Please indicate with a check mark what you have been treated for</th>
<th>Y</th>
<th>E</th>
<th>S</th>
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<th>Please indicate with a check mark what you have been treated for</th>
<th>Y</th>
<th>E</th>
<th>S</th>
<th>N</th>
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<tbody>
<tr>
<td>Ears/Nose/Throat</td>
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<td></td>
<td></td>
<td>Heart Disease</td>
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<td></td>
<td>CRONIC CONCERNS</td>
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<tr>
<td>Eyes</td>
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<td>Stroke</td>
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<td>Frequent Ear Infections</td>
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<td>Heart</td>
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<td>High Blood Pressure</td>
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<td>Hearing, Visual Disorder</td>
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<tr>
<td>Lungs</td>
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<td>Orthopedic Disorder, List:</td>
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<td>Skin</td>
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<td>Faintness during exercise</td>
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<td>Enuresis</td>
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<td>Dizziness during &amp; after exercise</td>
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<td>Neck</td>
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<td>Shortness of Breath</td>
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<td>Muscle Weakness</td>
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<td>Shoulder/Arms</td>
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<td>Joint/Pain stiffness</td>
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<td>Elbow/Forearm</td>
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<td>Heart Murmur</td>
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<td>Wrist/Hand</td>
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<td>High Blood Pressure</td>
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<td>Irregular Heart Beat</td>
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<td>Knee</td>
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<td>Seizures</td>
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<td>Leg/Ankle</td>
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<td>Orthopedic Injury</td>
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<td>Foot</td>
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<td>Weight Loss/Anorexia</td>
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Restriction of Activities? Yes ____  No ____  By whom? _____________________________________ What types of activities: ________________________________

Have you been hospitalized in the last year? ________ Reason: _____________________________________

Please date the last time you had your immunization for Diptheria-Tetanus-Petussis (DTP/DtaP) __________

________________________________________________________________________________________________________________________________________________________

**AUTHORIZATION FOR HEALTH CARE:** To the best of my knowledge, all information provided on this form is accurate and complete. I am in good health and able to participate in all Kanakuk Institute activities. I hereby give my permission to the physician selected by the Health Services Director and/or Institute President to order X-rays, routine tests, and treatment. In the event that I am incapacitated and my emergency contacts cannot be reached in an emergency, I hereby give my permission to the physician selected by the Health Services Director and/or Institute President to hospitalize, secure proper treatment, and order injections and/or anesthesia and/or surgery.

________________________________________________________________________________________________________________________________________________________

**STUDENT’S SIGNATURE IS REQUIRED** (In Ink)       **DATE**