Zion Apostolic International Bible College, Inc.

Medical Form

Please fill out the following form to ensure your medical information is recorded and that you meet the health requirements for enrollment at Zion Apostolic International Bible College, Inc.

Personal Information:
Full Name: _____
Date of Birth: _____
Gender: [ ] Male [ ] Female
Phone Number: _____
Email Address: _____
Emergency Contact Name: _____
Emergency Contact Phone: _____

Health History:
Please check any of the following that apply to you:
[ ] Asthma
[ ] Diabetes
[ ] Seizures
[ ] Heart Disease
[ ] High Blood Pressure
[ ] Allergies (please list): _____
[ ] Other (please specify): _____

Medical Clearance:
I hereby confirm that I am in good health and able to attend classes at Zion Apostolic International Bible College, Inc. I have been evaluated and there are no known communicable diseases.
I acknowledge that it is my responsibility to inform the College about any health conditions that may affect my participation in activities or classes.

Physician's Name: _____
Physician's Contact Information: _____
Physician's Signature: _____
Date: _____

Communicable Disease Clearance:
I hereby certify that I do not have any communicable diseases, including but not limited to Tuberculosis,

Hepatitis, or any viral infections. I understand that the College reserves the right to request further medical documentation if necessary.

Signature: _____
Date: _____

Declaration and Signature:
I, the undersigned, declare that the information provided on this form is correct to the best of my knowledge. I understand that if any health concerns arise, I am responsible for informing the appropriate school authorities. I agree to adhere to the school's health and safety protocols.

Signature: _____
Date: _____