# STUDENT'S HEALTH RECORD FORM - CONFIDENTIAL

*All information shall not be disclosed to any third party without prior consent from the student*

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Student's Name | | | | BruHims No | | | |
| Date of Birth | | Brunei Smart Card | | Colour | | Male ( ) | Female ( ) |
| Registration Number | | Telephone | | Email address | | | |
| Faculty | | | | Session | | | |
| Home Address | | | | | | | |

| Do you Suffer from: | Yes | No | If Yes, please give details (e.g. medications) |
|---|---|---|---|
| *Hypertension* | | | |
| *Hepatitis B* | | | |
| *Epilepsy* | | | |
| *Asthma* | | | |
| *Diabetes* | | | |
| *Cancer* | | | |
| *Allergies (including drug and non-drug allergies)* | | | |
| *Dyslexia* | | | |

| Do you wear: | | | |
|---|---|---|---|
| *Spectacles/ Contact Lens* | | | |
| *Hearing Aid* | | | |
| *Support Devices* | | | |

Do you have any special needs that we should be aware of to support your well-being in UBD?

( ) Visual ( ) Hearing ( ) Physical ( ) Learning Disability ( ) Others: _____ ( ) Translator (Language:_____)

Are you on regular medication? (please specify) ( ) Yes ( ) No (Please √)

*Please attach a copy of your physician card/ Patient's Health Booklet/ Outpatient Prescription (if any)

Any other medical information (please specify)

Declaration

I hereby declare that all information entered above is true to the best of my knowledge.

| | | | |
|---|---|---|---|
| Student's Signature | | Date: | |