基督工人神學院

Christian Witness Theological Seminary

健康資料表

Health History Form

1975 Concourse Drive, San Jose, CA 95131, USA. Tel: (408) 433-2280 Fax: (408) 433-9855 Email: admin@cwts.edu

Name of Applicant: Last Name (Surname) **First Name (Given Name)** **In Chinese**
申請人姓名：_____ _____ 中文姓名：_____

Name of Physician: Last Name (Surname) **First Name (Given Name)** **In Chinese (If applicable)**
醫生姓名：_____ _____ 中文姓名：_____

Address of Physician
醫生的地址：_____

_____

Does the applicant have or have had any of the following?
申請人是否有以下的症狀？

	Yes 有	No 沒有		Yes 有	No 沒有
Tuberculosis 肺結核	☐	☐	**Epilepsy 癲癇**	☐	☐
Heart Trouble 心臟病	☐	☐	**Paralysis 中風**	☐	☐
Fainting Spells 不省人事	☐	☐	**Diabetes 糖尿病**	☐	☐
Nervous Breakdown 精神衰弱	☐	☐	**Convulsion 痙攣**	☐	☐
Abnormal Blood Pressure 不正常升壓	☐	☐			

Immunization, what kind?
是否有預防注射？那一種？_____

Has he / she ever changed or advised to change his / she residence or occupation because of health reason?
他／她是否曾因健康緣故變更住處或被要求離職？ ☐ **Yes 有** ☐ **No 沒有**

Has he / she ever received treatment or has treatment been recommended by a physician for physical or emotional condition?
他／她曾否接受醫生的身體或心理的治療，或醫生建議他／她去接受治療？ ☐ **Yes 有** ☐ **No 沒有**

Any continuing health problem? **If yes, what is it?**
是否有持續的健康問題？ ☐ Yes 有 ☐ No 沒有 如果有的話，問題是什麼？_____

Does the applicant have any other disability which affects class attendance and participation (such as vision, hearing, or walking disability)?
申請人是否有會妨礙上課或參與學校活動的其他殘障問題？（如：視力、聽力或行動不便等等）

Remark
備註：_____

_____

Physician's Signature **Date**
醫生簽名：_____ 日期：_____