FLASH FRAME VISUALS ACADEMY OF FILM AND TELEVISION

HEALTH CERTIFICATE

MEDICAL INFORMATION MUST BE SUBMITTED WITH THE APPLICATION AT THE TIME OF REGISTRATION

(All information is confidential and will be used only to determine whether the applicant is able to safely handle the demands of teaching and training)

Name & Address ____

____

Tel. No. (R) ____________________ (Off) ____________________

Date of Birth ____

Person to be notified in an emergency. Name & Address ______________________________

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Tel. No. (R) ____________________ (Off) ____________________

Relationship with the applicant ______________________________

Family Doctor or Clinic, if any, to be consulted in an emergency. Name & Address ____________________

____

Tel. No (Clinic) ____________________ (Res) ____________________

Is the applicant covered by any medical insurance scheme? If so, give details ____________________

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This section to be completed by applicants Physician	Yes	No
Note: Physician & emotional strains in the profession & its education & training make it essential that specific replies to the following questions are given:		
1.Does applicant require or take any medications(s) or drug(s) regularly? If yes, give details: ____________	☐	☐

2.Does applicant have any serious disability of
(a). Vision ☐ ☐
If yes, give details: ___________________________

(b). Hearing ☐ ☐
If yes, give details: ___________________________

3.Has the applicant ever been trained or hospitalized
for drug abuse or emotional or psychological illness?
If yes, give details: ___________________________

4.Does applicant have any condition, which might limit ☐ ☐
participation in physically active classes?
If yes, give details: ___________________________

Signature of the applicant_______________________________

To be filled by the physician

I have examined Mr./Mrs _______________________________ on __________ and found the general condition of health to

be____

Name of the Physician________________________

Address____

Tel. No. (Clinic)____________________________ (Residence)___________________________

Place & Date_______________________________

____
Signature & Seal of the Physician