



*Beacon College Admissions Application  
Health Questionnaire*

**APPLICANT:** Please type or print your name in the gray area below, mark your choice, and return this form with your application.

Name \_\_\_\_\_

Please respond to the following question. This information is used by the Admissions Committee and the College to prepare for the medical, emotional, or social needs of our students, but is not required for admission.

- I agree to respond to the following questions.
- I would prefer not to respond to the following questions.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please circle your response and offer details if needed. Attach a sheet if more details are needed.**

Yes No **Seizures** Details: \_\_\_\_\_

Yes No **Allergies** Details: \_\_\_\_\_

Yes No **Traumatic Brain Injury or Head Injury**  
Date of Injury: \_\_\_\_\_ Age when injured \_\_\_\_\_  
Details: \_\_\_\_\_

Yes No **Depression or Anxiety**  
Current Medications: \_\_\_\_\_  
Details: \_\_\_\_\_

Yes No **Family History of Depression or Anxiety**  
Details: \_\_\_\_\_

Yes No **Family History of Learning Disabilities**  
Details: \_\_\_\_\_

Yes No **Other Medical Issues or Concerns (diabetes, CP, asthma, or other)**  
Details: \_\_\_\_\_

Yes No **Medications** Applicant can administer and manage medications independently? Yes No  
Details: \_\_\_\_\_

**Circle if any of the following symptoms, frequently trouble you:**

Yes	No	Indigestion	Yes	No	Constipation	Yes	No	Diarrhea
Yes	No	Sinusitis	Yes	No	Nervousness	Yes	No	Dizziness
Yes	No	Hay Fever	Yes	No	Sleeping Difficulty	Yes	No	Overly Tired
Yes	No	Overly Active	Yes	No	Eye Strain	Yes	No	Headache
Yes	No	Ear Infections	Yes	No	Insomnia	Yes	No	Nausea/Vomiting
Yes	No	Anger	Yes	No	Anxiety	Yes	No	Over Sleeping

Details: \_\_\_\_\_

**Please mark:**

Yes	No	Visual Defects	Yes	No	Speech/Language Deficits
Yes	No	Hearing Deficits	Yes	No	Hearing Problems
Yes	No	Emotional Problems	Yes	No	Physical Handicaps
Yes	No	Depression	Yes	No	Anxiety

Details: \_\_\_\_\_

Yes No Do you have any special dietary concerns (for example: diabetic, kosher, etc.)?

Details: \_\_\_\_\_

Yes No Do you require regular doctor or specialist appointments?  
If yes, please note the type of specialist so we may assist you in locating the appropriate physician locally.

Details: \_\_\_\_\_

Yes No Do you have regular or periodic appointments with a counselor for continued social/ emotional growth? If yes, please note the type of counseling services so we may assist you in locating the appropriate services locally.

Details: \_\_\_\_\_

**On a separate sheet, please describe any additional medical information that you feel could directly affect your ability to be successful while attending college away from your family and medical support systems.**