ABHTI
ANTIGUA & BARBUDA
HOSPITALITY
TRAINING INSTITUTE

MEDICAL FORM

Physician: Dr. ……..…… Tele #: …….

Name of student: ……..…… **DOB**…….. **Age:** ……..

Medical Condition: ☐Asthma ☐Diabetes ☐Seizure Disorders ☐Sickle Cell ☐Hypertension ☐Other

If Other – Explain: ……..…

……..…

Allergies: ☐Food ☐Latex ☐Medication ☐Dust ☐Other

If Other - Explain: …….

…….

Comments: _____

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Official stamp of Physician / Institution

P. O. Box 434 *Dutchman's Bay*
St. John's, Antigua *St. George's, Antigua*
Tel: 462-3066 *Fax: 462-8782*