



Student Health Questionnaire

Name: _____ Date of Birth: _____

Program Name

- Multi Media Makeup Artistry
- Fashion Makeup Artistry
- Production Makeup Artistry

Individual Classes

- Fundamental Make-Up Technique
- Airbrushing
- Fashion Makeup Boot Camp

Have you had or do you currently have any of the following conditions?

Please mark all that apply, specifying the date, whether past or present.

MEDICAL CONDITION	PLEASE CIRCLE	IF, YES PLEASE SPECIFY
1. Alcohol/Drug Addiction	Yes / No	_____
2. Allergies	Yes / No	_____
3. Asthma	Yes / No	_____
4. Cancer	Yes / No	_____
5. Chronic Condition	Yes / No	_____
6. Diabetes	Yes / No	_____
7. Eating Disorder	Yes / No	_____
8. Epilepsy / Seizure Disorder	Yes / No	_____
9. Frequent Trouble Sleeping	Yes / No	_____
10. Heart Disease	Yes / No	_____
11. Hypoglycemia	Yes / No	_____
12. Painful Shoulder, Knee, or Back	Yes / No	_____
13. Thyroid Condition	Yes / No	_____
14. Other: _____	Yes / No	_____
15. Do you hold any religious beliefs that might impact the provision of emergency medical treatment? Yes / No		
		If yes, please specify _____
16. Are you required to wear a health emergency bracelet? Yes / No		
		If yes, for what condition? _____

17. Have you had any injuries, which have required hospital or emergency room attention? For example, major accidents?

If yes, when, and for what? _____

18. Have you ever been hospitalized? Yes / No

If yes, when, and for what? _____

19. Have you had any surgical procedured? Yes / No

If yes, when, and for what? _____

20. Have you ever been treated for psychological / emotional problems? Yes / No

If yes, please describe the nature of the problem and list dates _____

21. Are you currently taking any medication? Yes / No

If yes, which medications and for what? _____

By my signature below, I hereby agree and attest:

I verify that all of the medical and psychological information I have provided is accurate and complete, and I will notify Cosmix School of Makeup Artistry of any changes in my health that occur prior to the start of the program and that occur during the duration of my attendance at Cosmix.

I hereby authorize Cosmix School of Makeup Artistry to use and/or disclose the information contained in this Student Health Questionnaire for purposes related to maintaining my health and well-being while participating in the program. I authorize the above-described information to be described information to be disclosed to Cosmix employees and representatives, and to the educational institution hosting my experience and their employees and representatives, and to any medical or health professionals they may deem appropriate. I understand that disclosure shall be limited to the minimum necessary amount of such information to accomplish the intended purpose(s) described in the preceding paragraphs.

This authorization shall expire upon completion of my program.

I have read and fully understand the above information.

Student Signature: _____ Date _____