THE UNIVERSITY OF THE WEST INDIES
MONA CAMPUS

STUDENT

CONFIDENTIAL

INSTRUCTIONS

- MEDICAL CERTIFICATE TO BE COMPLETED AND RETURNED TO THE ADMISSIONS SECTION
- MEDICALS MUST BE DONE **WITHIN THE THREE MONTHS PRECEDING** THE BEGINNING OF CLASSES

PART A: DECLARATION BY EXAMINEE

NAME: (BLOCK LETTERS) ……
Surname Other names

HOME ADDRESS: ……...

DATE OF BIRTH: ……. SEX: …….

NO. OF CHILDREN …… AGES ……

FATHER'S OCCUPATION ……

MOTHER'S OCCUPATION ……

FACULTY: …… ID#: ……..

PROGRAMMES: (Degree, Certificate, Diploma) ……

1. Have you been diagnosed with a chronic illness? e.g. cancer, hypertension, diabetes……...……

   If so, give details .....

2. Does any member of your family have a chronic illness? e.g. cancer, hypertension, diabetes ……

   If so, give details……

3. Are you taking any type of medication on a regular basis? ……..……...

   If so, name the drug(s) ……

4. Have you or any member of your family ever suffered from or been suspected of suffering from tuberculosis? ……..

   If so, give details ……..……...

5. Have you or has any member of your family ever suffered from mental disorders or seizures or been treated in an institution for any of these diseases? ……

   If so, give details ……..….

6. Have you or any member of your family ever suffered from or ever been suspected of suffering from Malaria ? …….

   If so, what type of Malaria was diagnosed? ……..…

7. Do you use alcohol, tobacco or any other recreational drug?

   …….....

8. Do you suffer from any physical disability? ……

9. Do you suffer from any allergies? If so, give details ……..

IMMUNIZATIONS

SECTION A

IMMUNIZATION RECORD (To be completed and **signed** by Medical Examiner)

THE FOLLOWING IMMUNIZATIONS ARE REQUIRED FOR **ALL** STUDENTS:

REQUIRED IMMUNIZATIONS	day/month/year	day/month/year	day/month/year	day/month/year
			Booster	Booster within past 10 years
DT/DPT (3 doses)				
OPV (3 doses)				
MMR (2 doses)				
BCG (1 dose)				
Varicella (2 doses) or disease date				

SECTION B **STUDENT**

THE FOLLOWING IMMUNIZATION IS MANDATORY FOR MEDICAL STUDENTS AND IS RECOMMENDED FOR ALL OTHER STUDENTS. THIS SHOULD BE DONE PRIOR TO ENTRY AND VERIFICATION PRESENTED TO THE UWI HEALTH CENTRE AT THE START OF THE ACADEMIC YEAR.

IMMUNIZATIONS	day/month/year	day/month/year	day/month/year	day/month/year	day/month/year
				Booster	Booster within past 10 years
Hepatitis B (3 doses)					

Please attach to this form a **certified copy** of your immunization card.

……..…

Signature of Examinee Date

PART B: EXAMINATION RESULTS

INSTRUCTIONS

The Health Services require students coming from countries outside of the Caribbean, United States and Canada to have a Tuberculin Skin Test **done within twelve months preceding the beginning of classes.** A chest X-ray report is required only if the test is positive. Please attach completed report to this form.

HAS APPLICANT EVER HAD A TUBERCULIN SKIN TEST? [ ] YES [ ] NO

TUBERCULIN (PPD) TEST **(WITHIN 12 MONTHS)**	**APPLIED**	**READ**	**RESULT**	**Nurse/MD signature**

1. HEIGHT ……. WEIGHT ……..
2. HEART …….. B. P. ……
3. LUNGS: ……...
4. NERVOUS SYSTEM: ……..

   PSYCHIATRIC ASSESSMENT ……..…..
5. ABDOMEN: ……..……
6. BONES AND JOINTS: …… DEFORMITIES ……..…
7. SKIN …….. TEETH ……..…..
8. HEARING ……R……L……...
9. SIGHT (a) WITHOUT GLASSES R 20/…….. L 20/……..…

   (b) WITH GLASSES R 20/…….. L 20/……..……

   (C) COLOUR VISION ……..……
10. URINALYSIS: SUGAR ……ALBUMEN…….……..…...
11. PLEASE REPORT RESULTS OF ANY OTHER INVESTIGATIONS (IF INDICATED) ……

    ……

REMARKS

……..

……..

……

Signature or Stamp REQUIRED:

……

Print Name of Medical Examiner Registration # Signature Date

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Office Address

Telephone …… Fax ……EMAIL……..……..….

NB: THE COMPLETED MEDICAL FORM SHOULD BE RETURNED IN A SEALED ENVELOPE CLEARLY LABELED **"STUDENT HEALTH FORM".**
THE SEALED ENVELOPE **MUST BE HANDED IN** ALONG WITH THE ACCEPTANCE CARD.