CONFIDENTIAL

THE UNIVERSITY OF THE WEST INDIES

MEDICAL CERTIFICATE TO BE COMPLETED AND RETURNED BEFORE ADMISSION

PART A DECLARATION BY EXAMINEE

NAME: *(Block letters)* ……

HOME ADDRESS: ……

DATE OF BIRTH: …… SEX ……

CHILDREN: …… AGES: ……

FATHER'S OCCUPATION: ……

MOTHER'S OCCUPATION: ……

FACULTY: ……

PROGRAMME: *(DEGREE, CERTIFICATE, DIPLOMA)* ……

1. Have you or has any member of your family ever had any serious illness or surgical operations? ……

   If so, give details ……

   ……

   ……

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

   If so, name the drug(s) ……

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

4. …… …… ……..

   If so, give details …… ……

   ……

5. Have any member of your family ever suffered from mental diseases, fits or epilepsy, or been treated in an institution for any of these diseases?

   If so, give details ……

   ……

6. Have you been immunised against:

TB	YES [ ]	NO [ ]
Tetanus	YES [ ]	NO [ ]
Polio	YES [ ]	NO [ ]
Diphtheria	YES [ ]	NO [ ]

7. Do you use Alcohol, Tobacco or any other drug? ……

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

I hereby certify that the information quoted above and supplied by me to the Medical Examiner is correct in every particular.

……..
Signature of Examinee
(To be made in presence of Medical Examiner)

PART B. EXAMINATION RESULTS

1. HEIGHTS……. WEIGHT ……...

2. HEART …… B.P. ……

3. LUNGS ……

4. NERVOUS SYSTEM ……

   PSYCHIATRIC ASSESSMENT ……

5. ABDOMEN ……

6. BONES & JOINTS …… DEFORMITIES ……

7. SKIN ……. TEETH ……

8. HEARING ……

9. SIGHT (A) WITHOUT GLASSES: R. …….. L ……..

   (B) WITH GLASSES *(If worn)* R …… L ……...

   (C) COLOUR VISION ……

10. URINE – IS SUGAR OR ALBUMEN PRESENT ……..

11. OTHER INVESTIGATIONS (If needed) ……

    ……

REMARKS

……..

……..

……..

……..

……
Signature of Medical Examiner

Date …….

Address …….

……..

Tel. # …….