UNIVERSITY OF TECHNOLOGY, JAMAICA
MEDICAL CENTRE
237 OLD HOPE ROAD,
KINGSTON 6
970-2245 ext. 2459

HEALTH HISTORY AND PHYSICAL EXAMINATION REPORT

This form ***must* be completed by the prospective student and signed by a Medical Practitioner. The medical form is to be submitted before or upon registration and no later than date of entry or registration. It is important to note that a completed medical form is vital for the processing of your registration. Students will not be registered without submitting their medical reports to the medical centre.**

NBAppointments can be made at the medical centre if you wish to have the medical done there at a cost of JA$2000.00. This fee does not include laboratory tests which may need to be done.**

Medical services at the Medical Centre

From coughs and colds to asthma and acne...we have a staff of expert clinicians to meet your medical needs in a caring and confidential environment. We know your health is important and your time is heavily scheduled, so we offer medical care on an open-access, walk-in basis. You can come in when you know that your preferred provider will be here to see you. Please let the Registered Nurses know which clinician you prefer to see! Waiting time will usually be longer during peak demand hours, but we will work to take care of your problem as efficiently as possible.

Confidentiality

It is against the law for Medical Centre to release medical information regarding any student 18 years of age or older to anyone—including parents—without written permission from the student.

Nonetheless, every effort is made, with the student's consent, to notify parents of serious medical problems. In situations where a student's safety is immediately in danger as a result of a medical or mental health problem, we may share information with your family to ensure your health and appropriate medical care.

Submission Date of Medical: _____

Student ID#: _____

Doctor's / Nurse's Signature: _____

Student / Staff Information

(***To be completed by student / staff***)

Student / Staff Name

_____

Surname First Name Middle Name

Faculty: ( ) FOBE ( ) COHS ( ) FELS ( ) FOBM ( ) FOEC ( ) LAW ( ) FOSS **Student ID Number**_____

Gender: ( ) Male ( ) Female **Date of Birth** ____/____/_____ (dd/mm/yy)

Permanent Home Address

_____
_____
_____

Contact Number

(H) _____ (C) _____

Email Address

_____

Permanent Emergency Contact

_____

(Name/Address/Relationship of contact person)

_____
_____
_____

(Contact Number)

Alternative Emergency Contact

_____

(Name/Address/Relationship of contact person)

_____
_____
_____

(Contact Number)

Please Tick √ Yes(Y) or No(N)

Past Medical History	Y	N	**Present Medical History**	Y	N	**Do you suffer any present symptoms**	Y	N
Mumps			Asthma			Anxiety		
Measles			Allergies			Chest pains		
Polio			Diabetes			Palpitations		
Tuberculosis			Heart Disease			Heart burn		
Rheumatic Fever			Hypertension			Shortness of breath		
Kidney Disease			Sickle Cell Disease			Female discharge		
Chicken Pox			Rheumatic Heart Disease			Male discharge		
Dengue Fever			Epilepsy/Seizure/Fits			Genital herpes		
Malaria			Thyroid Disease			Syphillis		
Lupus			Anaemia			Gonorrhoea		
			Migraine Headaches			Spitting blood		
			Muscular /Joint Disorder			Difficulty seeing		
			Systemic Lupus Erythematosus (SLE)			Difficulty hearing		
			Skin Disorder			Urinary frequency		
			Urinary Disorder			Urinary burning		
			Menstrual Disorder			Depression		
			Emotional/Nervous Disorder			Tension Headaches		

Part II (To be completed by a Nurse)

Height	**Weight**	**Blood Pressure**	**Pulse**
Visual Acuity	Right eye	Left Eye	
Urinalysis	Albumin	Sugar	Ph

Part III (To be completed by Medical Practitioner)

	Normal	**Abnormal**	**Physical Findings**
Eyes			
Ears			
Mouth			
Nose/Sinuses			
Throat			
Neck- Thyroid			
Cardiovascular			
Respiratory			
Abdomen			
Skin			
Musculoskeletal			
Reflexes			
Deformities			
Genitalia (LMP)			
Psychiatric			

Radiology Examination of Chest (OPTIONAL)
Chest X-ray Normal ( ) Abnormal ( )
Date of X-ray ____/_____/_____

Laboratory Investigations (REQUIRED)
Blood: CBC _____

Conclusion
Student/Staff is ( ) FIT ( ) UNFIT for admission into the University.

_____ _____ _____
Physician's Name Physician Signature Date of Examination

IMMUNIZATIONS

All students entering the University of Technology are required to show proof of their immunization status as part of their entry into the institution. To state that one is **"fully immunized"** or **"card not seen"** will not be accepted as there must be proof of such for the completion of medical examination and the registration process.

IMMUNIZATION	Date Given			Boosters		
BCG						
D.P.T						
Polio						
MMR (Measles Mumps Rubella)						
Measles						
D.T						
Other						

NB. Students who are entering the Faculty of Health and Applied Science and Hospitality and Tourism Management (foods) are expected to have obtained all three or have started the series of <u>Hepatitis B Vaccines.</u>

Please bring a copy of your Immunization Card with you.

Immunization	**Dates given**
Hepatitis B No.1	___/____/_____
Hepatitis B No.2	___/____/_____
Hepatitis B No.3	___/____/_____

MEDICATION HISTORY

If you are currently being treated for a medical condition please indicate what medication you are being treated with.

Medication

1. _____
2. _____
3. _____
4. _____
5. _____