

University of Vavuniya

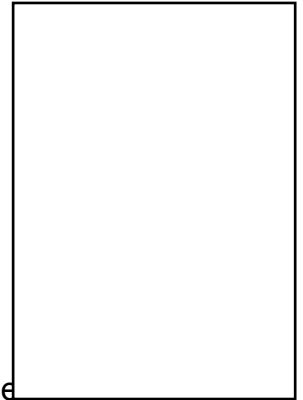
Student Medical Examination Report

Name with Initials :

Initial Denoted Name :

NIC No :

Enrolment No :



Health history form

This information is strictly confidential and is for the use of University Health Services. It should not be released to any one without your knowledge and consent.

Please send the completed form directly to the University Medical Officer, Health Centre, University of Vavuniya, Pambaimadu, Vavuniya before coming to the University.

Part I of the form should be completed by the student and **Part II** should be done in a government hospital where facilities are available and it should be signed and stamped. If the University Medical officer needs to examine a student on considering his/ her medical form, he/she should report immediately to the University Medical officer within short notice.

Part I

To be completed by the student.

Date of birth	Gender	Religion	Civil Status	Age	Nationality	Position of family
Last school attended	Occupation		Number of siblings (Sisters/ Brothers)	Home address and district		
	Father	Mother				

Extra Curricular activities during the school day. Sports / Music/ Dancing/ leadership/ Religious work/ Arts/ none.

Person to notify in case of emergency

Name :

Address :

Telephone No :

Relationship :

Family medical history

Members	Age	Alive/ State of Health	Dead/ age at death	Cause of Death
Father				
Mother				

Brother				
Sister				

Student Medical History

Have you suffered from any of the following?

- Infectious Diseases**- Mumps, Measles, Rubella, chicken pox, Infective Hepatitis, STI, Covid 19, Others.
- Respiratory**- Frequent cold, Hay fever, Asthma, Pneumonia, T.B, Others.
- Circulatory**- Heart Disease, Hypertension.
- E.N.T**- Ear infections, sinusitis, Tonsillitis, Hearing disorders, Others.
- Eye**- Short sight, Long sight, Injuries, Others.
- Nervous system**- Epilepsy, Migraine, Others.
- Surgical**- Fractures, Injuries, Others.
- MISC**- Anemia, Diabetes, Skin disorders, Kidney disease, Mental illness, Alcohol addiction, Others.
- Allergic History**- Drugs/ Food, If any specify
- Menstrual History (For Female only)**- Period –Regular/Irregular, Flow- Slight/ Normal/ Excessive, Pain - Yes/ No)
- Disability**- Do you believe that you have a disability that in any way requires you to receive special consideration from the University.... If so, please indicate the type of disability and give a brief description below.....

12. Immunization

Vaccinations	Date					
BCG						
DPT						
MR/ MMR						
Hepatitis B						
Covid - 19	1 st dose		2 nd dose		Booster	
	Date	Type	Date	Type	Date	Type

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Please attach a copy of Child Health Record and Covid Vaccination Card.

I certify that the information furnished by me are true and correct.

Date:-

Signature of the Student:

Part II

FOR USE OF MEDICAL OFFICER (to be completed by a M.B.B.S. qualified government doctor):

General medical information.

a. Has the student been successfully vaccinated?

Weight	Height	Circumference of chest	
		Full inspiration	Full expiration
Kg	cm		

1 **Condition of teeth-** Decayed (.....), Missing (.....), Dentures (.....), Gingivitis (.....)

2 **Hearing-** R ear L ear.....
Speech-

3 **Circulation-** Any past history of heart disease?
- Heart sound - - Murmurs -
- Blood pressure - - Pulse -

4 **Respiration**
- Past history of Tuberculosis, Bronchitis or Asthma?
- Special test for tuberculosis - Mantoux test.....
-X-ray chest.....

5 **Nervous Functions-**
- Any traces of convulsion, insanity or inebriety observable?
- Are knee jerks and pupils abnormal?

6 **Examination of Abdomen-**
- Any evidence of enlargement of liver or spleen?.....
- Whether subject to haemorrhoids?
- Hernial Orifices?
- Genitalia?
- Any other abnormalities?

7 **Vision-** without glasses – Rt- With glasses- Rt-
Lt-..... Lt-.....
Color vision- Normal /Blind -Red
Green

8 **Extremities and surface-**

- a. Are there any scars from operations, injuries?
- b. Are there varicose veins of any affection of the skin?.....
- c. Any bone or joint abnormalities?

9 **Clinical Tests**- Blood group & Rh , Hemoglobing/dl

10 Does the student Need referral to a specialist regarding any medical condition?
If so, what is the condition?

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I am of opinion that

Mr/Mrs/Miss

Is fit/ not fit for higher studies for the following reason:

.....

Date:

.....
Signature of Medical Officer/ Frank

Date:.....

.....
University Medical Officer