

A₇ -Medical Form

University of Vavuniya Student Medical Examination Report

Name with Initials :
Initial Denoted Name :
NIC No :
Enrolment No :
Student Telephone No :



Health history form

This information is strictly confidential and is for the use of University Health Service and will not be released to anyone without your knowledge and consent.

Please hand over the completed 'Student Medical Examination Report' to the student in a sealed envelope before the date of registration.

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 in the family (1 st , 2 nd , ... child)	Occupation	
							Father	Mother

Extra - Curricular activities / Sport:

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? (Please attach the diagnosis details if any)

1. **Infectious Diseases**- Mumps, Measles, Rubella, Chicken Pox, Infectious Hepatitis, STIs, COVID-19, Others.
2. **Respiratory**- Frequent cold, Hay fever, Asthma, Pneumonia, TB, Others.
3. **Circulatory**- Heart Disease, Hypertension.
4. **E.N.T**- Ear infections, sinusitis, Tonsillitis, Hearing disorders, Others.
5. **Eye**- Short sight, long sight, Injuries, Others.
6. **Nervous system**- Epilepsy, Migraine, Others.
7. **Surgical**- Fractures, Injuries, Others.
8. **Congenital Abnormalities**- Anemia, Diabetes, Skin disorders, Kidney disease, Mental illness, Alcohol addiction, others.
9. **Allergic History**- Drugs

Yes

No

Food

Yes

No

10. **Menstrual History (For Females only)**- Period –Regular/Irregular, Flow- Slight/Normal/Excessive, Pain - Yes/ No)
11. **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 annex the diagnosis card

12. Immunization

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 Hospital Use, where all specialized facilities are available

(All Examinations must be carried out and certified by a qualified specialist)

Name of the student: -.....

Date of Examination: -.....

Have you satisfied yourself of his/her identity?:.....

Signature
or
Thumb mark
or
Birthmark: -.....

General medical information.

A. Has the student been successfully vaccinated?

Yes

No

Weight	Height	Circumference of the chest	
Kg	cm	Full inspiration	Full expiration

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 History of convulsions or Insanity?
- Any abnormal pupil Reaction?

6 **Examination of Abdomen**-

- Any evidence of enlargement of liver or spleen?.....
- Presence of hemorrhoids
- Hernial orifices (any hernia)If Yes, please mention the details:.....
- Genital examination (any abnormalities) If Yes, please mention the details:.....
- 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 or injuries?
- b. Are there varicose veins or any abnormal skin conditions?.....
- c. Any bone or joint abnormalities?

9. Clinical Tests- Blood group & Rh, Hemoglobin g/dl

FBS.....

Examination of Urine

Reaction:.....

Specific Gravity:.....

Albumin:.....

Sugar:.....

Deposits:.....

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

.....
.....

I am of the opinion that

Mr./Mrs./Miss.....

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

.....

Date:.....

.....
Medical Examiner's Signature & Frank

Date:.....

Certified

.....
University Medical Officer