

**University of Vavuniya**  
**Student Medical Examination Report**

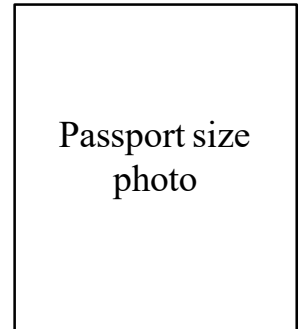
Name with Initials : .....

Initial Denoted Name : .....

NIC No : .....

Enrolment No : .....

Student Telephone NO : .....



**Health history form**

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

**Part I** of the form should be completed by the student. **Part II** should be completed in a **\*Government Hospital** where all specialized facilities are available, and it should be signed and stamped. If the University Medical Officer needs to examine a student after reviewing his/her medical form, the student should report immediately to the University Medical Officer on short notice.

**Part I**

**To be completed by the student.**

Date of birth	Gender	Religion	Civil Status	Age	Nationality	Position in the family (1 <sup>st</sup> , 2 <sup>nd</sup> ...child)	Occupation	
							Father	Mother

Extra-Curricular Activities / Sport: .....

**Person to notify in case of emergency**

Name .....

Permanent Address .....

Telephone No .....

Relationship .....

**Family medical history**

Members	Age	State of Health
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
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No
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Food 

Yes
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No
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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: -.....
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**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 - ..... ECG - .....  
- 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? .....  
- Any abnormal reflexes?.....

**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..... VDRL.....

**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

**\*Government Hospitals: - District General Hospital, Provincial Hospital, Teaching Hospital, National Hospital**