A_7 -Medical Form

University of Vavuniya

Student Medical Examination Report

Passport size photo

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 (1st ,2nd …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 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 UniversFormity. 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 - …….. 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**