University of Jaffna

Students Medical Examination Report

Photo

Full Name :.....

Student's ID. No :.....

Faculty :.....

Health history form

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

Please hand over the completed form directly to the Senior Assistant Registrar / Admissions, University of Jaffna or send by Registered post:- Senior Assistant Registrar, Admissions Branch, University of Jaffna, Thirunelvely, Jaffna.(please indicate as 'Medical Certificate' on the left hand corner of the envelope)

Part I of the form should be completed by the student and part II should be completed by MBBS qualified Medical Officer 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

<table>
<tr><th>Date of Birth</th><th>Sex</th><th>Religion</th><th>Single / Married</th><th>Age</th><th>Nationality</th><th>Position of Family</th></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td rowspan="2">Last School attended</td><td colspan="2">Occupation</td><td rowspan="2">Number of Siblings (Sisters / Brothers)</td><td colspan="3" rowspan="2">Home address and district</td></tr>
<tr><td>Father</td><td>Mother</td></tr>
<tr><td></td><td></td><td></td><td></td><td colspan="3"></td></tr>
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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	Deeds/age at death	Cause of Death
Father				
Mother				
Brother				
Sister				

Student Medical History

Have you suffered from any of the following?

01 **Infection Diseases**- Mumps, Measles, Rubella, Chicken pox, infective Hepatitis, Others.

02 **Worm infestations**- Round Worm, Hook worm, Thread worm, Tape worm, Filarial,

03 **Respiratory**- Frequent colds, Hay fever, Asthma, Pneumonia, T.B, Other.

04 **Circulatory**- Heart disease, Blood Pressure.

05 **E.N.T**-Ear infections, sinusitis, Tonsillitis, Others

06 **Eye**- short sight, Long sight, infection, injuries, Others.

07 **Nervous system**- Epilepsy, Migraine, Others.

08 **Surgical**-fractures, injuries, Others.

09 **Misc.** -Anaemia, Diabetes, indigestion, Skin disorders, kidney disease, Attempted suicide, Alcohol addiction, Depression, Other.

10 **Allergic History**-Drugs/Food.

Respiration

-Past history of Tuberculosis, Bronchitis or Asthma?.....

-Special test for tuberculosis-Mantoux test……..

-X-ray chest…….

Nervous Functions

-Any traces of convulsion, insanity or inebriety, observable?.....

-Are knee jerks and pupils abnormal?.....

Examination of Abdomen

-Any evidence of enlargement of live or spleen?.....

-Whether subject to haemorrhoids?.....

-Hernial Orifices…….

-Genitalia…….

-Any other abnormalities?.....

Vision-without glasses -Rt……. **-with glasses** -Rt…….

-Lt……. -Lt……..

Colour Vision-Normal/blind Red

Green

Extremities and surface

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

Clinical Tests- Blood group & Rh…… Haemoglobin…… g/dl.

Does the student Need referral to a specialist regarding any medical condition?

If so, what is the

Condition?.....
.....
.....

I am of opinion that

Mr./Mrs./Miss ……

IS FIT / NOT FIT FOR HIGHER STUDIES FOR THE FOLLOWING REASONS:

……

Date: …….. ……

Signature of Medical Officer/frank.

Date: …… ……..

University Medical Officer.

Menstrual History (for Female only)-

Period-Regular/ Irregular, Flow:Slight / Normal / Excessive, Pain-Yes / No

Disability- Do you believe that you have a disability a that in any way requires you to receive special consideration from the University. if so, please indicate the type of disability and give a briefdescription
below……

………..

Immunization

Vaccinations	**Date**
BCG	
DRT	
MR/MMR	
Rubella	
Hepatitis B	
Chickenpox	

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

Date…….. Signature of the student: ……..

Part II

FOR UES 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 cheat**	
kg	**cm**	**Full inspiration**	**Full expiration**

01 Condition of teeth-Decayed (…..), Missing(…..), Dentures(…..), Gingivitis(…..)

02 Hearing-R ear……. L ear…….

Speech ……..

03 Circulation- Any past history of heart disease?.....

-Heart sound-……. -Murmurs…….

-Blood pressure…… -Pulse……..