UNIVERSITY OF TECHNOLOGY, JAMAICA
MEDICAL CENTRE
237 OLD HOPE ROAD,
KINGSTON 6
Telephone :-(876)970-5466, (876)702-3313
EXT:-2466

HEALTH HISTORY AND PHYSICAL EXAMINATION REPORT

This form mustbe completed by the prospective student and signed by a Medical Practitioner. The medical form is to be submitted before or upon registration and no later than date of entry or registration. It is important to note that a completed medical form is vital for the processing of your registration**.**

Students will not be issued their ID card without submitting completed medical forms along with photocopy / original lab results and copy of immunization card.

Please note the following requirements to proceed for medicals:-

- Appointments can be made via telephone if one wishes to complete medicals at the University; **otherwise**, it can be done at a private physician and then submitted to the UTech, Ja. Medical Centre, laboratory results must be attached upon submission.
- Complete the 'Student and General Information' section.
- Provide original and a photocopy of one's immunization card.
- Medical costs **JA$3000.00** if done at UTech, Ja. Medical Centre and you must arrive **30 minutes before your appointment time**.
- Mandatory laboratory tests attract an additional cost – Biomedical Lab (located in the UTech, Ja. Medical Centre).
- Vaccines are available, at an additional cost.
- Students entering College of Health sciences (COHS), Faculty of Science and Sport (FOSS) and Joint College of Medicine, Oral Health and Veterinary Science (JOINT COLL) are mandated to get Hepatitis B, Influenza and Varicella Vaccines.

Payment options include use of Credit/Debit card at the UTech, Ja. Medical Centre or cash payments at the cashier post at the Accounts Department (receipt must be provided as proof of payment).

*****Health Insurance cards are not accepted for medicals, claim forms are available upon request.***

OFFICE USE ONLY

Student ID Number: _____

Submission date of medical: _____

UTech, Ja. doctor/nurse signature: _____

Check Box
( ) Completed medical form
( ) Photocopy of lab results
( ) Original and photocopy of immunization record.

Student and General Information

Part I *(To be completed by Student)*

Last Name _____ **First Name** _____ **Middle Name** _____

Date of Birth ____/____/____(DD/MM/YYYY) **Gender**: ( ) Male ( ) Female **Disability** ( ) Yes ( ) No

Faculty: ( ) COBAM ( ) COHS ( ) FELS ( ) FENC
( ) FOSS ( ) FOBE ( ) FOLW ( ) Joint Coll.

Student ID Number _____

Contact Number (H) (___)_____(C) (___)_____ Email Address _____

Home Address

_____

_____

Emergency Contact (Relation)

_____
(Name) (Contact)

(Address)

Please tick yes or no below. If YES please specify (treatment, time of diagnosis, medication)

Present Medical History		Do you suffer any present symptoms		Past Medical Symptoms	
Yes	No	Yes	No	Yes	No
( )	( ) Asthma	( )	( ) Anxiety	( )	( ) Mumps
( )	( ) Allergies	( )	( ) Chest pains	( )	( ) Measles
( )	( ) Anaemia	( )	( ) Palpitations	( )	( ) Polio
( )	( ) Diabetes	( )	( ) Heart burn	( )	( ) Tuberculosis
( )	( ) Heart Disease	( )	( ) Shortness of breath	( )	( ) Rheumatic fever
( )	( ) Hypertension	( )	( ) Depression	( )	( ) Kidney disease
( )	( ) Sickle Cell Disease	( )	( ) Spitting blood	( )	( ) Malaria
( )	( ) Rheumatic Heart Disease	( )	( ) Abnormal female discharge	( )	( ) Lupus
( )	( ) Thyroid Disease	( )	( ) Male discharge	( )	( ) Chicken pox
( )	( ) Headaches	( )	( ) Difficulty seeing	( )	( ) Dengue fever
( )	( ) Muscular/ Joint Disorder	( )	( ) Difficulty hearing	( )	( ) Chikungunya virus
( )	( ) Skin Disorder	( )	( ) Urinary frequency		
( )	( ) Urinary Disorder				
( )	( ) Menstrual Disorder				
( )	( ) Epilepsy/Seizure/Fits				
( )	( ) Emotional/Nervous Disorder				
( )	( ) Autoimmune Disease				

Allergies (specify type): _____

Prior Surgery(s): _____

Medication history: _____

Disability (if yes to above): _____

Additional comments:_____

Physical Examination

Part II *(To be completed by a Nurse)*

IMMUNIZATION	Date Given			Boosters			
BCG							
D.P.T							
Polio							
MMR (Measles Mumps Rubella)							
Measles							
D.T							
Hepatitis B							
Other							

Height (cm)	**Weight** (kg)	**Blood Pressure** (mm/Hg)	**Pulse** (bpm)
Visual Acuity	Right eye	Left Eye	
Urinalysis	Albumin	Sugar	pH

Part III *(To be completed by a Medical Practitioner/Nurse Practitioner)*

	Normal	**Abnormal**	**Physical Findings**
Eyes			
Ears			
Mouth			
Nose/Sinuses			
Throat			
Neck/ Thyroid gland			
Cardiovascular			
Respiratory			
Abdomen			
Skin			
Musculoskeletal			
Reflexes			
Deformities			
Genitalia (LMP)			
Psychiatric			

Laboratory Investigations: CBC _____ **(ATTACH COPY OF RESULTS)**

Conclusion

Student is ( ) FIT ( ) UNFIT for admission into the University.

_____ Date of examination

_____ Physician Signature

_____ Medical Council of Jamaica Stamp