UNIVERSITY OF TECHNOLOGY, JAMAICA
MEDICAL CENTRE
237 OLD HOPE ROAD,
KINGSTON 6
876-970-2245
studentmedical@utech.edu.jm

HEALTH HISTORY AND PHYSICAL EXAMINATION REPORT

This form must be 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 registered without submitting their medical reports to the medical centre.

NB Appointments made at the medical centre to have the medical done is at a cost. This fee does not include laboratory tests as the onsite laboratory is an independent entity.**

Medical services at the Medical Centre

From coughs and colds to asthma and acne...we have a staff of expert clinicians to meet your medical needs in a caring and confidential environment. We know your health is important and your time is important so we offer medical care by appointment.

Please let the Registered Nurses know which clinician you prefer to see! Waiting time will usually be longer during emergencies but we will work to take care of you as efficiently as possible.

Confidentiality

Release of medical information regarding any student 18 years of age or older to anyone—including parents—with written permission from the student is practiced.

Note that every effort is made with the student's consent, to notify parents of serious medical problems. In situations where a student's safety is imminently in danger as a result of a medical or mental health condition, we may share information with your family to ensure your health and appropriate medical care.

Submission Date of Medical: _____

Student ID#: _____

Doctor's / Nurse's Signature: _____

Student Information

(***To be completed by student***)

Student Name

_____

Surname First Name Middle Name

Faculty: ( ) FOBE ( ) COHS ( ) FELS ( ) FOBM ( ) FOEC ( ) LAW ( ) FOSS **Student ID Number**_____

Gender: ( ) Male ( ) Female **Date of Birth** ____/____/_____ (dd/mm/yy)

Permanent Home Address

_____

_____

_____

Contact Number

(H) _____ (C) _____

Email Address

_____

Permanent Emergency Contact

_____

(Name/Address/Relationship of contact person)

_____

_____

_____

(Contact Number) _____

Alternative Emergency Contact

_____

(Name/Address/Relationship of contact person)

_____

_____

_____

(Contact Number)_____

Please Tick √ Yes(Y) or No(N)

Past Medical History	Y	N	**Present Medical History**	Y	N	**Do you suffer any present symptoms**	Y	N
Carcinoma			Allergies			Chest pains		
Cardiac Disease			Anaemia			Difficulty hearing		
Chicken Pox			Asthma			Difficulty seeing		
COVID-19			Diabetes			Female discharge		
Dengue			Emotional/Nervous Disorder			Heart burn		
Kidney Disease			Epilepsy/Seizure/Fits			Male discharge		
Lupus			Heart Disease			Palpitations		
Malaria			Hypertension			Shortness of breath		
Measles			Menstrual Disorder			Spitting blood		
Mumps			Migraine Headaches			Tension Headaches		
Polio			Muscular /Joint Disorder			Urinary burning		
Renal Disease			Rheumatic Heart Disease			Urinary frequency		
Rheumatic Fever			Sickle Cell Disease /Trait					
Tuberculosis			Skin Disorder					
Surgeries:			Systemic Lupus Erythematosus (SLE)					
			Thyroid Disease					
			Urinary Disorder					

MEDICATION HISTORY

If you are currently being treated for a medical condition other than stated above, please indicate below and all medication prescribed.

Medical Condition(s): _____

_____

Medication(s):

1. _____
2. _____
3. _____
4. _____
5. _____

Part II

Height	**Weight**	**Blood Pressure**	**Pulse**	**Visual Acuity**	**Urinalysis**	
				Right eye	Albumin	Ph
				Left Eye	Sugar	

Part III (To be completed by Medical Practitioner)

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

Student required learning/learning support ( ) Complete Disability Form ( )

Recommendation/Additional Notes

_____

_____

_____

IMMUNIZATIONS

All students entering the University of Technology are required to show proof of their immunization status or receive booster doses as recommended by the medical practitioner. To state that one is **"fully immunized"** or **"card not seen"** will not be accepted.

Please bring a copy of your Immunization Card with you.

IMMUNIZATION	Dates Given			Boosters		
BCG						
D.P.T						
Polio						
MMR (Measles Mumps Rubella)						
Measles						
D.T						
Hepatitis B						
Influenza						
COVID-19						
Varicella						
Other:						

NB. Students who are entering the Faculty of Health and Applied Science and Hospitality and Tourism Management (foods) are expected to have obtained all three or have started the series of Hepatitis B Vaccines.

Required Test – CBC ( )

Additional tests requested _____

Conclusion

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

_____ _____ _____

Physician's Name Physician Signature Date of Examination