



# THE UNIVERSITY OF THE WEST INDIES MONA CAMPUS

**CONFIDENTIAL**

**MEDICAL CERTIFICATE TO BE COMPLETED AND RETURNED TO THE ADMISSIONS SECTION**

**PART A: DECLARATION BY EXAMINEE**

NAME (*Block Letters*): .....

HOME ADDRESS: .....

DATE OF BIRTH: ..... SEX: .....

NO. OF CHILDREN: ..... AGES: .....

FATHER'S OCCUPATION: .....

MOTHER'S OCCUPATION: .....

FACULTY: ..... ID#: .....

PROGRAMMES: (**Degree, Certificate, Diploma**): .....

1. Have you or has any member of your family ever had any serious illness or surgical operation?

.....

*If so, give details* .....

2. Are you taking any kind of medication on a regular basis? .....

3. Have you or has any member of your family ever suffered from or being suspected of suffering from tuberculosis? .....

*If so, give details* .....

4. Have you or has any member of your family ever suffered from mental diseases, fits or epilepsy or been treated in an institution for any of these diseases? .....

*If so, give details* .....

**5. IMMUNIZATIONS**

**SECTION A**

The following immunizations are required for **ALL** students:

	mo./day/year	mo./day/year	mo./day/year
DPT or DT			
DT Booster			
Polio			
MMR			
Rubella			

**SECTION B**

The following immunization is **mandatory for medical students** and is recommended for all other students:

	mo./day/year	mo./day/year	mo./day/year
Hepatitis B Series			

**SECTION C**

The following immunization is recommended for all student but is not mandatory:

	mo./day/year	mo./day/year	mo./day/year
Varicella (Chicken Pox) Series			

**Please attach to this form a copy (certified by your medical examiner or an officer of the Admissions Section) of your original immunization record.**

6. Do you use alcohol, tobacco or any other drug? .....

7. Do you suffer from any physical disability? .....

.....  
Signature of Examinee

**PART B: EXAMINATION RESULTS**

- 1. HEIGHT: ..... WEIGHT: .....
- 2. HEART: ..... B.P. ....
- 3. LUNGS: .....
- 4. NERVOUS SYSTEM: .....  
PSYCHIATRIC ASSESSMENT: .....
- 5. ABDOMEN: .....
- 6. BONES & JOINTS: ..... DEFORMITIES: .....
- 7. SKIN: ..... TEETH: .....
- 8. HEARING: .....
- 9. SIGHT (A) WITHOUT GLASSES R: ..... L: .....  
(B) WITH GLASSES R: ..... L: .....  
(C) COLOUR VISION .....
- 10. URINE – IS SUGAR OR ALBUMEN PRESENT? .....
- 11. OTHER INVESTIGATIONS (*If needed*): .....

**REMARKS**

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.....

.....  
Signature of Medical Examiner

Date: .....

Address: .....

.....

Telephone: ,.....

**NB: The completed Medical Form should be returned in a sealed envelope clearly labelled “STUDENT HEALTH FORM”. The sealed envelope MUST be handed in along with the Acceptance of Offer form.**