CONFIDENTIAL

THE UNIVERSITY OF THE WEST INDIES
ST. AUGUSTINE

MEDICAL CERTIFICATE TO BE COMPLETED PRIOR TO ACCEPTANCE FOR ADMISSION TO THE UNIVERSITY OF THE WEST INDIES

GUIDELINES FOR COMPLETING FORM

1. **Part A** is to be completed and signed by the applicant.
2. **Part B** is to be completed by a registered Medical Practitioner who has examined the applicant.
3. **INTERNATIONAL APPLICANTS** - applicants coming to Trinidad **from malarious countries** are required to report to the Student Medical Officer at the Health Service Unit **IMMEDIATELY** upon their arrival
4. All students must show evidence of immunization against **MEASLES**, **RUBELLA** and **TETANUS.** In such cases where immunization is medically contraindicated, there should be a signed statement from a physician giving reason for contraindication.
5. All Faculty of **MEDICAL SCIENCES** applicants are required to have **HEPATITIS B** immunization and to complete full **TUBERCULOSIS** screening. In addition, D.V.M. applicants are required to have RABIES immunization
6. The completed Admission Medical Certificate should be submitted for validation at the **HEALTH SERVICE UNIT SIX WEEKS** prior to commencement of the semester…or within 30 days after receipt of the form if you are a late acceptance or transfer student. Students who do not comply with the requirements by the deadline, must report to the Health Service Unit on arrival on campus and correct any remaining deficiencies before registration.

N.B. The tear-off portion, which is to be returned to the student, must be presented at registration and is to be retained on the student's file. Students will not be permitted to register without this form.

(Please print in BLOCK letters)

PART A

Name: ____
Surname *First Name*

Faculty: ______________________________ SEX: M F

Address: ____

Age: __________ Name of Parent/Guardian/Next of Kin ____________________

Have you been a student at UWI previously? [ ] Yes [ ] No

If yes, state Campus and period ____________________________________

Telephone contact: ______________________________

	NO	YES	DETAILS
1. Do you suffer from any chronic disease or disability?			
2. Have you or any member of your household suffered from tuberculosis?			
3. Have you ever had a mental disorder?			

I certify that the foregoing information is true and complete to the best of my knowledge. I realize that the information that I have given in the medical history section is confidential and for the use of the Health Service Staff. I give permission to the University of the West Indies to furnish such diagnostic, therapeutic, voluntary immunization and operative procedures and transportation as may be deemed necessary on my behalf. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of treatment or examination by the Health Service Staff.

Student's name (Block Letters) ______________________________

Student's Signature : ______________________________

Date: ______________________________

(Please print in BLOCK letters)

PART B

All three sections to be completed by the physician AFTER Part A has been completed by applicant.)

Please note below any conditions you consider significant

If there is any other information of which we should be aware please submit separately under confidential cover.

PHYSICAL EXAMINATION

Height (cm.) Weight (kg.)

	NO	YES	COMMENTS
1. *Is there any abnormality on general physical examination including urine test?*			
2. *Is there any physical or mental disability, which might handicap the candidate in his/her studies?*			
3. *Is there any evidence of recent infectious disease?*			
4. *Is there any history of Allergies such as reaction to Penicillin, Eczema and Asthma?*			
5. *Has the applicant been treated or is being treated for any of the following: (tick)* *Asthma* *Epilepsy* *Diabetes* *Hypertension*			

IMMUNIZATION RECORD

TYPE	YR. MTH. DAY	SIGNATURE
MMR 1		
MR		
HEPATITIS B		
TETANUS		

TUBERCULOSIS SCREENING

1. **Does the student have signs or symptoms of active TB disease?** **YES** **NO**

   If **NO**, proceed to Question 2. If **YES**, proceed with additional evaluation to exclude active TB disease including tuberculin skin testing, chest X-ray and sputum evaluation as indicated.

2. **Is the student a member of a high-risk group or is the student entering the Faculty of Medical Sciences.** **YES** **NO**

   If NO, stop. No further evaluation is needed.
   If YES, place tuberculin skin test (Mantoux only: Inject 0.1ml of purified protein derivative (PPD) tuberculin containing 5 tuberculin units (TU) intradermally into the volar (inner) surface of the forearm.) A history of BCG vaccination should not preclude the testing of a member of a high-risk group.

3. **Tuberculin Skin Test:**
   Date given: ___ /____ /____ Date Read: ____/____ /____

   Result:____________ (Record actual mm of induration, transverse diameter; If no induration, write "0")
   Interpretation (based on mm of induration as well as risk factors): Positive: Negative:

4. **Chest X-ray (required if tuberculin skin test is positive):**

   Results: Normal__________________ Abnormal ______________________

   Date of Chest X-ray: _____/_____ /_____

Physician's Name or Stamp________________________________**Signature**___________________________

Address:____**Date:**________________

DO NOT WRITE BELOW THIS LINE – FOR HEALTH SERVICE USE ONLY

COMPLETE			**INCOMPLETE**
Date form reviewed: By whom (sign.)	Health History Permission	Tetanus Hepatitis B	Date form reviewed: By whom (sign.):
Date completed:	MMR	TB Screening	