THIKA SCHOOL OF MEDICAL AND HEALTH SCIENCES LTD

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MEDICAL REPORT

PART I – TO BE FILLED BY THE APPLICANT

A. Do you suffer from any physical disability? Yes/No ……

If yes, state the type of disability ……..

B. Have you ever been admitted in the hospital? Yes/No …….

If yes, state the type of illness and hospital admitted …….
…….

C. Have you suffered from any sickness in the last one year? Yes/No ……..……..

If yes state the sickness and the hospital/clinic where you were treated ……..
…….

D. Do you suffer from any chronic disease? Yes/No ……

If yes state the hospital/clinic where you attend and the routine medication/check up …….
…….

E. Do you suffer from any allergy related to any medication? Yes/No …….

If yes describe the condition ……..
…….

Signature …… Date ……...

PART II – PARENT/GUARDIAN

A. Which hospital do you prefer for referral (admission) purposes if need be? (If yes which one?)

i. Private Hospital ……..

ii. Public Hospital ……..

B. Do you have a personal/family Doctor? Yes/No ……..

If yes, state who and contacts …….
…….

C. Do you agree to pay for any costs incurred by your child or sponsor(student) in another hospital if need be?

Yes/No ……

D. Who can we contact in case of emergency?

Name: ……
Address: ……..
Tel No.: ……...
Mobile No.: ……
Email: ……....
Signature: …… Date: ……..

PART III – TO BE FILLED BY THE DOCTOR OR PHYSICIAN

NAME OF STUDENT …… DATE ……..

EYE VISION: RIGHT …… LEFT ……...

EARS …… NECK ……

R.S. …….. C.V.S ……....

C.N.S ……...

URINALYSIS ……..

STOOL TEST ……..

PREGNANCY TEST ……...

CHEST X-RAY ……...

NAME OF DOCTOR/PHYSICIAN ……...

SIGNATURE …… OFFICIAL RUBBER STAMP …….