

SECTION 1

(PART B) – Please tick (√) in the relevant box

Declaration of self and family illness. Explain in full if you or your family has any of the following illness

* Immediate family refers to father, mother, brother / sister

MEDICAL PROBLEMS	SELF		IMMEDIATE FAMILY		If “ Yes” please state
	Yes	No	Yes	No	
1. Congenital or inherited disorder					
2. Allergy					
3. Mental illness					
4. Fits, stroke, other neurological disease					
5. Diabetes Mellitus					
6. Hypertension					
7. Heart or vascular disease					
8. Asthma					
9. Thyroid disease					
10. Kidney disease					
11. Cancer					
12. Tuberculosis					
13. drug addiction					
14. AIDS, HIV					
15. History of surgery					
16. Other illnesses					

Current medication (Long term)

IMMUNIZATION HISTORY (where applicable)	DATE IMMUNIZED				
1. Yellow Fever					
2. BCG					
3. Meningitis (Quadrivalent)					
4. Hepatitis B					
5. Other :					

I hereby certify that the information given above is true. I understand that my application will be rejected if there is any false information given.

Date

Signature of candidate

SECTION 2 – PHYSICAL EXAMINATION

To be filled by examining doctor

1. BASIC MEASUREMENT	
HEIGHT : _____ m	BLOOD PRESSURE : _____ mmHg
WEIGHT : _____ m	PULSE RATE : _____ / min
VISION TEST: Unaided :(R) _____ (L) _____ Aided :(R) _____ (L) _____	COLOUR VISION TEST : NORMAL / ABNORMAL

2. GENERAL EXAMINATION			
ITEM	YES	NO	COMMENT
a. DEFORMITIES			
b. PALLOR			
c. CYANOSIS			
d. JAUNDICE			
e. OEDEMA			
f. SKIN DISEASES			

3. SYSTEM EXAMINATION			
ITEM	NORMAL	ABNORMAL	COMMENT
a. EYES(including funduscopy)			
b. EARS			
c. NOSE			
d. ORAL CAVITY / THROAT			
e. NECK			
f. HEART			
g. LUNGUS			
h. ABDOMENT / HERNIAORICES			
i. NERVOUS SYSTEM			
j. MENTAL CONDITION			
k. MUSCULOSKELETAL SYSTEM			

SECTION 3 - INVESTIGATION

URINE TEST		
ITEM	DATE TAKEN	RESULT
a. ALBUMIN		
b. SUGAR		
c. MICROSCOPIC		
d. MORPHINE		
e. CANNABIS		
f. AMPHETAMIN TYPE STIMULANT		

BLOOD TEST		
ITEM	DATE TAKEN	RESULT
a. HEPATITIS Bs ANTIGEN		
b. HEPATITIS C		
c. HIV		
d. VDRL / THPA		
e. MALARIAL PARASITE		

CHEST X-RAY INFORMATION	
CHEST X-RAY	
DATE TAKEN	
PLACE TAKEN	
REPORT	<hr/> <hr/>

SECTION 4 - CERTIFICATION BY THE EXAMINING DOCTOR

Please tick (√) in the appropriate box

I certify that I have on this date _____ examined

Mr / Ms _____ Passport No. _____

and found him / her:-

IN GOOD HEALTH

HAVING THE FOLLOWING MEDICAL COMPLICATION (S) (Please state)

UNDERGOING TREATMENT FOR: (Please state)

Date _____

Signature of Doctor : _____

Name of Doctor : _____

Qualification : _____

Hospital/Clinic

Registration number : _____

Official stamp : _____

Remarks by University / College Official: