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MEDICAL EXAMINATION FORM FOR STUDENTS

Programme Applied For:
☐ Ordinary Diploma in Nursing and Midwifery
☐ Ordinary Diploma in Physiotherapy
Academic Year: _____

A. PARTICULARS OF THE APPLICANT

1. **Full Name:** _____
2. **Date of Birth:** _____
3. **Sex:**
   ☐ Male ☐ Female
4. **Nationality:** _____
5. **Postal/Residential Address:**

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6. **Telephone Number:** _____
7. **Emergency Contact/Next of Kin:** _____
8. **Relationship:** _____
9. **Telephone Number:** _____

B. MEDICAL HISTORY

Please indicate whether the applicant has ever suffered from any of the following conditions:

Medical Condition	Yes	No	Remarks
Tuberculosis	☐	☐	
Asthma	☐	☐	
Epilepsy/Seizures	☐	☐	
Diabetes Mellitus	☐	☐	
Hypertension	☐	☐	
Heart Disease	☐	☐	
Kidney Disease	☐	☐	
Liver Disease	☐	☐	
Chronic Respiratory Disease	☐	☐	

Mental/Psychiatric illness	☐	☐
Major Surgery	☐	☐
Serious Accident/Injury	☐	☐
Any other chronic illness	☐	☐

Other relevant medical history:

Current medication, if any:

C. PHYSICAL EXAMINATION

1. General Examination

Height: _____ cm
Weight: _____ kg
BMI: _____ kg/m²

General appearance: _____

2. Vital Signs

Temperature: _____ °C

Pulse: _____ beats/min

Respiratory Rate: _____ breaths/min

Blood Pressure: _____ mmHg

SpO_2: _____ %

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3. System Examination

System	Findings/Remarks
Cardiovascular System	_____
Respiratory System	_____
Gastrointestinal System	_____
Central Nervous System	_____
Musculoskeletal System	_____
Genitourinary System	_____
Skin	_____
Eyes/Vision	_____
Ears/Hearing	_____
Oral/Dental Health	_____

D. VISION AND HEARING ASSESSMENT

Vision

Right Eye: _____

Left Eye: _____

With/Without Correction: _____

Colour Vision: ☐ Normal ☐ Abnormal

Hearing

Right Ear: ☐ Normal ☐ Impaired

Left Ear: ☐ Normal ☐ Impaired

Remarks: _____

E. LABORATORY/OTHER INVESTIGATIONS

The following investigations may be performed according to institutional requirements and the medical practitioner's assessment:

Investigation	Result	Remarks
Full Blood Count (FBC)	_____	_____
Urinalysis/UPT	_____	_____
Blood Glucose	_____	_____
Other	_____	_____

Additional investigations recommended:

F. MEDICAL FITNESS DECLARATION

Following the medical history, physical examination and investigations considered necessary, I certify that:

Name of Applicant: _____

has been medically examined and is:

☐ **MEDICALLY FIT** to undertake the **Ordinary Diploma in Nursing and Midwifery**

☐ **MEDICALLY FIT** to undertake the **Ordinary Diploma in Physiotherapy**

☐ **MEDICALLY FIT WITH RECOMMENDATIONS/RESTRICTIONS**

☐ **NOT CURRENTLY MEDICALLY FIT** to undertake the programme

Medical Remarks/Recommendations

G. MEDICAL PRACTITIONER'S DETAILS

Name of Medical Practitioner: _____

Professional Registration Number: _____

Designation: _____

Name of Health Facility:

Address: _____

Telephone: _____

Signature: _____

Official Stamp:

Date of Examination: _____ / _____ / _____

H. FOR OFFICIAL USE ONLY
Admission/Registration Number: _____
Programme: _____
Academic Year: _____
Medical Form Received: ☐ Yes ☐ No
Verified By: _____
Signature: _____
Date: _____ / _____ / _____
Institutional Stamp: