SAMUEL JACKMAN PRESCOD INSTITUTE OF TECHNOLOGY
DIVISION OF STUDENT SERVICES

STUDENT MEDICAL FORM

You must complete this Medical Form and email it to the Student Services Officer from whom your correspondence was sent when returning your acceptance form.

Part A must be completed and signed by the applicant and Part B and C must be completed and signed by the registered Medical Practitioner who conducted your examination.

PLEASE TICK ☑ THE APPROPRIATE BOX

PART A

STUDENT NAME: ____ **STUDENT NUMBER:** ________________

PROGRAMME: ____

ADDRESS: ____

TELEPHONE NUMBER: ___________________ **EMAIL ADDRESS:** ______________________________

MEDICAL HISTORY

NAME OF PRIMARY PHYSICIAN: ____

ARE YOU CURRENTLY USING MEDICATION? PLEASE TICK☑: **YES** ☐ **NO** ☐

IF YES, PLEASE STATE THE PURPOSE AND NAME OF THE MEDICATION:

____

____

STATE ANY MEDICAL CONDITION(S).

ALLERGIES ☐ HYPERTENSION ☐ MENTAL HISTORY ☐ EPILEPSY ☐

FAINTING ☐ ASTHMA ☐ DIABETES ☐

STATE ANY PHYSICAL OR PSYCHOLOGICAL DISORDER OR DISABILITY INCLUDING DYSLEXIA (Attach official documents)

__________________________________ ______________________________
SIGNATURE **DATE**

PART B - IMMUNISATION VERIFICATION FORM

(TO BE COMPLETED BY PHYSICIAN. All boxes MUST be completed.)

IMMUNISATION HISTORY		
IMMUNISATIONS AGAINST	**DATES (PHYSICIAN VALIDATED DATE OF VACCINATION)**	
Tetanus, Diphtheria and Pertussis	**DPT:**	
Measles, Mumps, German (Rubella)	**MMR 1:**	**MMR 2:**

Poliomyelitis	OPV/IPV:		
Hepatitis B **(Required by Nursing Auxiliary Studies, Hairdressing Skills, Massage Therapy and Beauty Therapy students ONLY)**	**1ST DOSE**	**2ND DOSE** (4 weeks after)	**3RD DOSE** (6 months after)
Varicella (Without Evidence of Immunity) **(Required by Nursing Auxiliary students ONLY)**	**1ST DOSE**	**2ND DOSE** (4 weeks after)	

Please indicate below any conditions you consider significant:

MEDICAL HISTORY	NO	YES	DETAILS
Is there any abnormality on general physical examination including investigations on urine tests, blood tests X-rays and ECG?			
Is there any physical or mental disability, which can potentially affect the candidate in his/her studies?			
Is there a history of allergies to drugs such as penicillin, aspirin or allergic conditions such as asthma, eczema, food?			
Is there any evidence of recent infectious disease?			
Has the candidate been treated for any of the following? Asthma, epilepsy, diabetes, hypertension, other chronic illness			

PART C - HEALTH CERTIFICATE

(Required by students in the Division of Human Ecology only, except for the Garment Technology students)

☐ This is to certify that I have on this day examined this student and that in my opinion he/she is: Free from infectious diseases likely to be spread through the contact with the skin and/or the handling of food and is otherwise in a fit state of health to be employed in cosmetology and/or food handler.

☐ In good health

☐ Suffering from ____

☐ Unable to attend school until ____

PHYSICIAN'S NAME: ____

ADDRESS: ____

TELEPHONE: ______________________ **EMAIL ADDRESS**: ______________________

______________________ **PHYSICIAN'S SIGNATURE**

______________________ **DATE**