CONFIDENTIAL

THE UNIVERSITY OF THE WEST INDIES
ST. AUGUSTINE

MEDICAL FORM TO BE COMPLETED ON ACCEPTANCE FOR ADMISSION TO THE UNVERSITY OF THE WEST INDIES, ST. AUGUSTINE CAMPUS

All students registering at the St. Augustine Campus of The University of the West Indies (UWI) for the first time must submit a completed **Medical Form** to the Medical Officer at the UWI Health Services Unit. **This is a compulsory requirement in order to become a registered student at UWI St. Augustine Campus.** The form consists of 3 parts and it is valid for 5 years from the date of the submission.

The signed Medical form must be submitted for validation with an **Immunization Card** at the UWI **HEALTH SERVICES UNIT SIX (6) WEEKS** prior to the commencement of the semester or within 30 days after receipt of the form, if you are a late acceptance or UWI transfer student. Candidates who do not comply with the requirements by the prescribed deadline, must report to the UWI Health Services Unit on arrival and correct any remaining deficiencies BEFORE registration.

GUIDELINES FOR COMPLETING THIS MEDICAL FORM

PART A – PATIENT HEALTH QUESTIONNAIRE

1) **All students** are required to complete Sections 1 to 5 of this form.
2) It is recommended that you visit the following website: http://sta.uwi.edu/health/ to also complete this part of the form online.

PART B – IMMUNIZATION RECORD

1) This section is to be completed and signed by a Healthcare Provider.
2) **Mandatory Vaccines** are required by **all students** entering The University of the West Indies.
3) **Students living on Halls of Residence** must show evidence of vaccination against **Varicella** (chicken pox) (2 doses).
4) **All Students** registering for programmes under the **Faculty of Medical Sciences** are required to show additional evidence of immunization against **Hepatitis B** (3 doses**), Varicella** (2 doses) and a **Tuberculosis Skin Test** (Mantoux). A Chest X-Ray report may be submitted in lieu of a Tuberculin Skin Test (Mantoux). Additionally only students pursuing the **D.V.M.** programme are required to show evidence of immunization against **RABIES**.
5) **International students** coming to Trinidad and Tobago from **Malaria endemic countries** are required to report to the Student Medical Officer at the UWI Health Services Unit **IMMEDIATELY** upon their arrival
6) **Students** are encouraged to have the **recommended vaccinations** even if they are not mandatory for their registered programme.
7) This completed Immunization Record must be submitted together with an Immunization Card and the signed Medical form for validation at the UWI Health Services Unit.

PART C – MEDICAL CERTIFICATE OF EXAMINATION

1) **Only students** entering the **Faculty of Medical Sciences** are required to complete Part C of this form.
2) This section is to be completed by a Medical Practitioner and includes a full medical examination and the Tuberculosis Screening.
3) Students entering the Faculty of Medical Sciences can present themselves at the Eric Williams Medical Sciences Complex, Chest Clinic to undergo a TB Screening. This can be done between the hours of 8.00 am to 1.00 pm on a Monday, Tuesday or Friday.
4) **A Chest X-Ray is required ONLY if the TB Screening is positive**.

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THE UNIVERSITY OF THE WEST INDIES
ST. AUGUSTINE

MEDICAL FORM TO BE COMPLETED ON ACCEPTANCE TO THE UNIVERSITY OF THE WEST INDIES

PART A – PATIENT HEALTH QUESTIONNAIRE

SECTION ONE: STUDENT INFORMATION

Name:_____ Date of Birth: _____/___/_____
Surname *First Name*

Faculty:_____ Age: _____ Gender: M ☐ F ☐

Address:_____

Student Registration Number_____ Contact#: _____ E-mail: _____

Name of Parent/Guardian/Next of Kin_____ Contact # _____

Name of Primary care physician _____ Contact # _____

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

If yes, state Campus and year of entry_____

SECTION TWO: GENERAL HEALTH

Please indicate by circling the appropriate answer

Do you have any physical or learning disabilities? Yes / No If yes, please explain _____

_____

Have you had any surgeries, significant injuries or hospitalization? Yes / No If yes, please describe and list the dates_____

_____

Are you currently on any medications/herbal preparations? Yes / No If yes, please state the medication and the dosage_____

_____

Are you allergic to any types of food, substances and/or medication? Yes / No If yes, please list_____

SECTION THREE: FAMILY HISTORY

Father: Alive / Deceased _____ Mother: Alive / Deceased _____

Siblings: (Number) Alive_____ / Deceased _____

Please indicate in the appropriate box if any of your immediate relatives have been diagnosed with any of the following medical conditions

	Yes	No	Relation		Yes	No	Relation
Arthritis				Heart Disease			
Asthma				High Blood Pressure			
Cancer				Mental Health Disorder			
Depression				Substance Abuse (drug/alcohol)			
Diabetes				Tuberculosis			
Seizures				Sickle Cell/ Anemia/Thalassemia			
Kidney Disease				Other			

SECTION FOUR: MEDICAL HISTORY

Please indicate in the appropriate box if you have been diagnosed with any of the following medical conditions.

	Y	N		Y	N		Y	N
Anxiety/Depression			Heart Disease			Substance Abuse		
Asthma			Hepatitis/Jaundice			Thyroid Disease		
Autoimmune disease (lupus)			High Blood Pressure			Physical Disability		
Bleeding Disorder			High Cholesterol or lipid disorders			Tuberculosis		
Bone Joint problems			Kidney/Bladder Disease			**ALLERGIES**		
Cancer			Malaria			Penicillin		
Chicken Pox			Migraine /Severe Headaches			Sulfur		
Chronic Cough			Polycystic Ovary Syndrome			Other Antibiotics		
Diabetes			Maternal illness			Codeine		
Disabilities			Psychiatric Condition			Aspirin		
Eating Disorder			Psychotherapy			Foods		
Female or Menstrual Problem			Recent Unexplained Weight Change			Dust		
Gum/Dental Disorder			Seizures/Blackouts			Wasp/Bee Stings/Fire Ants		
Head Injury			Sexually Transmitted Infections			Other:		
Hearing impairment			Skin Disorders					

SECTION FIVE: STATEMENT OF CONSENT FOR TREATMENT & CONFIDENTIALITY

I, _____ _____of _____ do hereby authorise the **Health Services Unit (HSU)** of The University of the West Indies, St. Augustine Campus ("the University") to release **my *name and relevant information pertaining to my health*** to employees of the University specifically authorised to receive such information, in circumstances where such information may be required for purposes related to my academic status/standing within the University.

I further authorise the HSU to release **my name, relevant information pertaining to my health and/or my medical records** to authorised health service providers in circumstances where my health is, or may be in jeopardy and where due to ill health or injury, I may not have the capability to communicate my consent to the release of said information for preserving my life or safeguarding me from further injury.

I hereby acknowledge that the **HSU** is authorised to release the information herein specified, for the sole purposes herein described and I declare that this consent has been given by me voluntarily under no duress or threat of duress, without inducement, promise or guarantee being communicated to me.

Accordingly, I release, indemnify and hold harmless the University, its officers, employees, agents, and servants acting on behalf of the University from any and all claims and/or liability arising from or in any way related to the dissemination of my name and medical information and/or records to the above stated recipient(s) and/or for the above stated purpose.

I hereby acknowledge that I have read and understood the nature and conditions of this consent and release.

_____ ____/____/____ _____ ____/___/___

Signature of Student **Date** **Signature of Parent/ Guardian if student under age 18** **Date**

PART B – IMMUNIZATION RECORDS

IMMUNIZATIONS REQUIRED FOR STUDENTS ENTERING THE UNIVERSITY OF THE WEST INDIES TO BE COMPLETED AND SIGNED BY A HEALTHCARE PROVIDER

Please print in BLOCK letters

NAME OF STUDENT _____
Last First

_____ _____
Date of Birth Student Registration #

MANDATORY VACCINES:

All Students

- **Measles, Mumps, Rubella (MMR) (*two doses required*)**
  Dose 1: _____/_____/_____mm/dd/yyyy (Given at age 12-15 months or later)
  Dose 2: _____/_____/_____mm/dd/yyyy (Given at age 4-6 year or later, or 1 mth after 1st dose)
- **Tetanus-Diptheria (Td)** Date: _____/_____/_____mm/dd/yyyy *(Given within the last 10 years)*

For Students Living on Halls of Residence

- **Varicella (*two doses required)***
  Dose 1: _____/_____/_____mm/dd/yyyy
  Dose 2: _____/_____/_____mm/dd/yyyy (Given at least 1 mth after the 1st dose)

For Students Entering the Faculty of Medical Sciences

- **Hepatitis B *(three doses required*)**
  Dose 1: _____/_____/_____ mm/dd/yyyy
  Dose 2: _____/_____/_____ mm/dd/yyyy
  Dose 3: _____/_____/_____ mm/dd/yyyy
- **Varicella (*two doses required)***
  Dose 1: _____/_____/_____mm/dd/yyyy
  Dose 2: _____/_____/_____mm/dd/yyyy (Given at least 1 mth after the 1st dose)
- **Rabies** Date: _____/_____/_____mm/dd/yyyy **DVM Students only**

RECOMMENDED VACCINES – (Although Not Essential / Required)

All students are encouraged to have the following vaccinations even if they are not mandatory for their registered programmes.

- **Varicella (*two doses required)***
  Dose 1: _____/_____/_____mm/dd/yyyy
  Dose 2: _____/_____/_____mm/dd/yyyy (Given at least 1 mth after the 1st dose)
- **Hepatitis B *(three doses required*)**
  Dose 1: _____/_____/_____ mm/dd/yyyy
  Dose 2: _____/_____/_____ mm/dd/yyyy
  Dose 3: _____/_____/_____ mm/dd/yyyy
- **Influenza *(annually*)**
  Date: _____/_____/_____mm/dd/yyyy

_____ _____ _____
Signature of Healthcare Provider **Date** **Printed Name or Office Stamp**

PART C – MEDICAL CERTIFICATE OF EXAMINATION

Part C is to be completed by a **Medical Practitioner** for students entering the **Faculty of Medical Sciences ONLY.** A **Chest X-Ray** is required only if the TB Screening is **positive.**

TO THE EXAMINING PHYSICIAN OR HEALTHCARE PROVIDER: We appreciate your thoroughness in reviewing the patient's medical history and completing Part C of this form by performing a physical examination and a tuberculosis screening.

Please print in BLOCK letters

NAME OF STUDENT ———————————————————————— Date of Birth ____/____/___
Last First

Date of Exam _____/_____/_____ _____ Gender: Male/Female
mm/dd/yyyy Student Registration #

SECTION 1: PHYSICAL EXAMINATION – Please evaluate the following and note any abnormalities

Weight (kg)	Height (m)	Blood Pressure:	Pulse Rate:	BMI:

NORMAL (√)		ABNORMAL (√)	COMMENTS
	Head, Ears, Nose or Throat		
	Respiratory		
	Cardiovascular		
	Gastrointestinal		
	Eyes (Refractive)		
	Eyes (Other)		
	Genitourinary		
	Musculoskeletal		
	Metabolic/Endocrine		
	Skin		
	Joint Function		
	Lymph nodes		
	Chest		
	Heart		
	Vascular System		
	Endocrine System		
	Neurological System		
	Dental		

SECTION 2: TUBERCULOSIS SCREENING

Students entering the **Faculty of Medical Sciences** can present themselves at the Eric Williams Medical Sciences Complex, Chest Clinic to undergo a TB Screening. This can be done between the hours 8.00am and 1.00pm on a Monday, Tuesday or Friday. **ALL RESULTS ARE TO BE SUBMITTED FOR VERIFICATION AT THE UWI HEALTH SERVICES UNIT.**

1. Does the candidate have signs or symptoms of active TB disease? Yes ☐ No ☐

   If YES, proceed with additional evaluation to exclude active TB disease including Tuberculin Skin Test (Mantoux), Chest X-Ray and sputum evaluation as indicated.

2. Is the candidate a member of the high-rick group or is the candidate 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 0.1 ml 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-rick group.

3. **Tuberculosis 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):**

   Result: Normal: ——— Abnormal: ——— Date of Chest X-Ray _____/_____/_____

SECTION3: PHYSICIAN VERIFICATION

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Name of Physician **Signature of Physician**

Physician's Stamp

Address

Medical Board Registration Number **Date**