PRE- ADMISSION HEALTH CHECK UP FOR RESIDENTS/STUDENTS

DECLARATION

(STRIKE OUT WHICH EVER IS NOT APPLICABLE)

I……..,son/daughter/wife of..... ……., aged…….....…years do hereby declare that I have no pre-existing or current medical or psychiatric illness which prevents me from performing the duties and responsibilities of a Student of the ..... course as stipulated by Head of the Department of …… ..... ……..

I agree to undergo the necessary medical examination and blood investigation prescribed for this screening procedure.

OR

I……., son/ daughter/ wife of ..... ……,aged…….....…years have..... ……..(disease) since the last. ……months/ years. I hereby declare that I am able to carry out the responsibilities and duties of a Student of the ……..... …….course as stipulated by Head of the Department of ……..…….....

I agree to undergo the necessary medical examination and blood investigation prescribed for this screening procedure.

Place: Signature
Date: Name

FORMAL MEDICAL SCREENING

A. MEDICAL HISTORY

Any current medical illness (if present-specify the illness, whether under treatment, whether the condition is under control)

1. Neurological-Epilepsy, neuromuscular illness, others
2. Respiratory-Active pulmonary TB, Bronchial asthma, others
3. Cardiovascular-CAD, Valve lesions, CHD, Others
4. Others-Viral hepatitis, any other blood-borne infections.

5. **Past history:**
    a) Hospitalization History:
    b) TB, Viral hepatitis, epilepsy, psychiatric illness etc

6. Current medications
7. If the candidate is a female (if pregnant), weeks of gestation.

B. EXAMINATION (specify the type of abnormality)

Hepatitis –B vaccine taken on (Date):

(1st):……(2nd)…… (3rd)……

Height:..... Weight:.....Pulse:.....BP:.....

General Exam

- Neurological
- CVS
- Respiratory
- Abdomen
- Any additional observations

C. INVESTIGATIONS

(Candidate has to consent for the following investigations)

1.Blood Investigations:

- HIV (Consent) – Report to be sent only to Director.
- HbSAg
- Hep C

2. Visual Acuity:

(without glass)…….. (With glass)……..(Power of glass).....……

I hereby declare that the information provided by me during the medical screening is true and correct to my knowledge; if at any stage during my course in the Institute, if it is found to be false, necessary action may be taken against me.

Signature of Candidate

Recommendations from the screening Physician (Provisional):

A. Fit to discharge duties as a Student

B. Needs further evaluation - specify.

Signature of the Physician:

Name:

Place: Designation :

Date: Medical Council Regn.No:

(Hospital seal)