



Applicants are required to return the completed MEDICAL RECORD form to the Campus Nurse at the Oakes Field or Northern Bahamas Campus along with their original Immunization Card by the last Friday in March (fall admits) or the last Friday in October (spring admits).

PART A: GENERAL INFORMATION

LAST NAME FIRST NAME MIDDLE NAME

ADDRESS (House #) (Street Name)

P.O. BOX NO.: TELEPHONE: (Home) (Work) (Cell)

DATE OF BIRTH: AGE: SEX: MALE [] FEMALE []

UB ID NUMBER: YEAR ENTERING UB: SEMESTER:

TYPE OF DEGREE: MAJOR:

CAMPUS: GROSVENOR [] OAKES FIELD [] NORTHERN BAHAMAS [] OTHER

ENROLMENT STATUS: FULL-TIME [] PART-TIME []

MARITAL STATUS: MARRIED [] SINGLE [] DIVORCED [] NUMBER OF DEPENDENTS:

EMPLOYMENT: FULL-TIME [] PART-TIME [] NOT EMPLOYED []

FOR ATHLETES: LIST SPORT(S):

ENGAGED IN INTRAMURAL: LIST SPORT(S):

FAMILY MEDICAL HISTORY: Have any of your immediate family members had any of the following?

Anxiety Yes [] No [] Depression Yes [] No [] Heart disease Yes [] No []
Asthma Yes [] No [] Diabetes Yes [] No [] High blood pressure Yes [] No []
Cancer Yes [] No [] Emotional disorders Yes [] No [] Tuberculosis Yes [] No []

Other (please specify):

PERSONAL HEALTH HISTORY

ALLERGIES TO FOOD (Please list):

ALLERGIES TO MEDICATION (Please list):

MEDICINES ROUTINELY TAKEN:

HEALTH INSURANCE (Check those that apply): National Health Insurance [] Private Health Insurance [] None []

HAVE YOU HAD OR SOUGHT ASSISTANCE FOR ANY OF THE FOLLOWING

Abuse	Yes [] No []	Kidney disease	Yes [] No []
Asthma	Yes [] No []	Learning disabilities	Yes [] No []
Bahaviour	Yes [] No []	Prolonged depression	Yes [] No []
Cancer	Yes [] No []	Rheumatic fever	Yes [] No []
Diabetes	Yes [] No []	Severe menstrual cramps	Yes [] No []
Emotional related problems	Yes [] No []	Sexually Transmitted Diseases	Yes [] No []
High blood pressure	Yes [] No []	Stomach/Gastric problems	Yes [] No []
Hearing impairments	Yes [] No []	Tuberculosis	Yes [] No []
Heart problems	Yes [] No []	Urinary infections	Yes [] No []
Hepatitis	Yes [] No []	Vision impairment	Yes [] No []

LIST ANY MAJOR ILLNESS: _____

LIST ANY MAJOR SURGERY: _____ / _____ / _____
 Day / Month / Year

LIST ANY MINOR SURGERY: _____ / _____ / _____
 Day / Month / Year

LIST ANY SPORTING INJURY: _____

NOTE:

1. Students with a chronic illness must submit the at-risk-register from their school health services.
2. Students must submit any previous psychological or learning evaluation(s).
3. Athletes must submit any previous copy of medical record of injury or at-risk-register from their high school.

EMERGENCY CONTACT

LAST NAME	FIRST NAME	RELATIONSHIP

STREET ADDRESS	TELEPHONE: (Home) / (Work)	(Cell)
_____	_____ / _____	_____

The information in Part A of this form is correct and complete to the best of my knowledge.

 Signature of Student or Parent (If student is under 18 years of age) Date

PART B: TO BE COMPLETED BY APPLICANT’S PERSONAL PHYSICIAN

Please perform a comprehensive examination and tick the following if abnormal, stating other concerns in the space provided:

Eyes []	Heart []	Skin []
Ears []	Vascular []	Lymph Nodes []
Nose []	Lungs []	Muscular/Skeletal []
Mouth []	Breast []	Anxiety []
Throat []	Abdomen []	Neurological []
Thyroid []	Depression []	Spine []
Chest []	Bipolar disorder []	Vision []

Special needs (physical/other) [] Prescription glasses [] Contact lenses [] Hearing aid []

Other Medical or Psychological Concerns: _____

VITAL SIGNS

Pulse: _____ Blood Pressure: _____ Temperature: _____ RBS: _____
Height: _____ Weight: _____ BMI: _____ Respiration: _____
Audiology: _____ Ophthalmology: _____

BLOOD INVESTIGATIONS

Hb: _____ Blood Group: _____
Sickle Cell Disease: _____ Hepatitis/HBsAg: _____ HIV: _____
Mantoux – Date Given: _____ / _____ / _____ Results: _____
Day / Month / Year
Chest X-ray (if Mantoux pos.): _____ / _____ / _____ Results: _____
Day / Month / Year

REQUIRED IMMUNIZATION (Please update P.R.N.)

NOTE:
1. Students 40 years and under are required to have: either 2 doses of MMR or 1 dose of MMR plus 1 dose of measles and 1 dose of rubella vaccine.
2. Students must present evidence of a completed D.T. booster within the last ten years.

D.P.T.: Primary series completed _____ / _____ / _____ POLIO: Primary series completed _____ / _____ / _____
dy. mo. yr. dy. mo. yr.
Last D.T. BOOSTER _____ / _____ / _____ (Repeat if over 10 years duration) _____ / _____ / _____
dy. mo. yr. dy. mo. yr.
MMR VACCINE: 1st Dose _____ / _____ / _____ 2nd Dose _____ / _____ / _____
dy. mo. yr. dy. mo. yr.
MEASLES VACCINE _____ / _____ / _____ RUBELLA VACCINE _____ / _____ / _____
dy. mo. yr. dy. mo. yr.
HEP. B: PRIMARY SERIES: _____ / _____ / _____ _____ / _____ / _____ _____ / _____ / _____
Day / Month / Year Day / Month / Year Day / Month / Year
VARICELLA: _____ / _____ / _____ _____ / _____ / _____ _____ / _____ / _____
Day / Month / Year Day / Month / Year Day / Month / Year

By signing this form, I confirm that a comprehensive physical examination was completed on the applicant/student.

PHYSICIAN'S NAME (Please Print) SIGNATURE DAY / MONTH / YEAR

BUSINESS ADDRESS: Street Name BUILDING/OFFICE No. TELEPHONE