UNIVERSITY OF THE BAHAMAS

MEDICAL RECORD

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 June (fall admits) or the last Friday in October (spring admits).

PART A: GENERAL INFORMATION

____
LAST NAME FIRST NAME MIDDLE NAME

__________ / ____
ADDRESS (House #) (Street Name) (Email Address)

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

DATE OF BIRTH: _____/___________/_________ AGE: ____________ SEX: MALE [ ] FEMALE [ ]
Day / Month / Year

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 [ ]
Behavior	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 [ ]

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: ____________

BLOOD INVESTIGATIONS

CBC: ________________________ Blood Group: _____________________________

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 ____/_____/________ dy. mo. yr.

POLIO: Primary series completed _______/________/______ dy. mo. yr.

Last D.T BOOSTER ____/______/________ dy. mo. yr.

(Repeat if over 10 year duration) _______/________/______ dy. mo. yr.

MMR VACCINE: 1st Dose ____/_______/________ dy. mo. yr.

2nd Dose ______________________

RUBELLA VACCINE _____/___________/______ dy. mo. yr.

MEASLES VACCINE _____/_________/________ dy. mo. yr.

HEP B: PRIMARY SERIES: _____/__________/_________ dy. mo. yr. _____/________/_______ dy. mo. yr. ___/_________/________ dy. mo. yr.

VARICELLA: _____/________/_________ dy. mo. yr. ______/__________/___________ dy. mo. yr. ______/____________/__________ dy. mo. yr.

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