University of the Commonwealth Caribbean

Student Health Record

PHYSICIAN'S REPORT OF HEALTH EVALUATION

To the Examining Physician: Please review the student's report and complete this physician's form, with comments on all positive answers. Since this student has already been accepted for admission, the information supplied will not affect his or her status and will be used only as background for providing any needed care by the Student Health and Counseling Services. It will not be released without the student's consent.
This form should be given to the student, who will return it to the University.

Name _____ Gender O Female O Male
Last First Middle

Blood Pressure _____ Height _____ in/cm

Urinalysis Sugar _____ Albumin _____ Micro _____ Weight _____ lbs/kgs

Haemoglobin (if indicated) _____ gms

Are there any abnormalities of the following systems?

	Yes	No	Describe fully
Head, Ears, Nose, or Throat			
Respiratory			
Cardiovascular			
Hernia			
Eyes			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			

Is there loss or seriously impaired function of an organ? O Yes O No
Explanation _____

Recommendations for physical activity (eg. sports): O Unlimited O Limited
Explanation _____

Do you have any recommendations regarding the care of this student? O Yes O No
If so, what? _____

Is the patient now under treatment for any medical condition? O Yes O No
Diagnosis _____

Has the student been under the care of a medical specialist? O Yes O No
If so, please list any medical restrictions _____

Is the patient now under treatment for any psychological condition? O Yes O No
Diagnosis _____
General comments? _____

Physician's Signature _____
Address _____
Last Name Printed _____
Date _____

Immunizations **REQUIRED**

Measles/Mumps/Rubella **Dates**
(must have two MMRs)
Dose #1 (month/day/year) _____
Dose #2 (month/day/year) _____

Tetanus/Diphtheria/Tdap _____

Meningococcal _____

Chicken Pox/Varicella _____
State if had disease
_____

Immunizations **RECOMMENDED**

Hepatitis B First _____
Second _____
Third _____

Gardasil/HPV First _____
Second _____
Third _____

Hepatitis A First _____
Second _____

Tuberculosis _____

PHYSICIAN'S STAMP