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/healthy/ 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.
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

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Relation</th>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Relation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td></td>
<td></td>
<td>Heart Disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td>High Blood Pressure</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td>Mental Health Disorder</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
<td>Substance Abuse (drug/alcohol)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td>Tuberculosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizures</td>
<td></td>
<td></td>
<td>Sickle Cell/ Anemia/Thalassemia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Disease</td>
<td></td>
<td></td>
<td>Other</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

SECTION FOUR: MEDICAL HISTORY

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

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

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

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
**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** _____/_____/____

**Date of Exam** _____/_____/______ **Gender:** Male/Female

**mm/dd/yyyy** **Student Registration #**

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

<table>
<thead>
<tr>
<th>Weight (kg)</th>
<th>Height (m)</th>
<th>Blood Pressure:</th>
<th>Pulse Rate:</th>
<th>BMI:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NORMAL (✓)</strong></td>
<td><strong>ABNORMAL (✗)</strong></td>
<td><strong>COMMENTS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head, Ears, Nose or Throat</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
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<tr>
<td>Cardiovascular</td>
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<tr>
<td>Gastrointestinal</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Eyes (Refractive)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Eyes (Other)</td>
<td></td>
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<tr>
<td>Genitourinary</td>
<td></td>
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<tr>
<td>Musculoskeletal</td>
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<tr>
<td>Metabolic/Endocrine</td>
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<tr>
<td>Skin</td>
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<tr>
<td>Joint Function</td>
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<tr>
<td>Lymph nodes</td>
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<tr>
<td>Chest</td>
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<tr>
<td>Heart</td>
<td></td>
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<tr>
<td>Vascular System</td>
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<td></td>
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<tr>
<td>Endocrine System</td>
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<tr>
<td>Neurological System</td>
<td></td>
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</tr>
<tr>
<td>Dental</td>
<td></td>
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</tbody>
</table>
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-risk 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-risk 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 _____/_____/______

SECTION 3: PHYSICIAN VERIFICATION

Name of Physician __________________________ Signature of Physician __________________________

Address ____________________________________________

Medical Board Registration Number __________________________ Date __________________________

Physician’s Stamp