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 Health Services Unit. This is a compulsory requirement in order to become a registered student at the UWI St. Augustine Campus. This 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 HEALTH SERVICES UNIT SIX 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. Scanned copies in PDF format only of the completed Medical Form and your Immunization Card are to be submitted via email to: doctor@sta.uwi.edu OR nurse@sta.uwi.edu. Candidates who do not comply with the requirements upon deadline, must contact the Health Services Unit on arrival or email queries to the above email addresses 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 Section 1 to 5 of this form.
2) It is recommended that you visit the following website: http://sta.uwi.edu/health/ to download the form.

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).
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 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. Varicella Titers are recommended if the student had chicken pox during childhood.
5) International students coming to Trinidad from Malaria endemic countries are required to report to the Student Medical Officer at the 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 Entrance Medical must be submitted together with an Immunization Card for validation at the 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 hospital stays? Yes / No     If yes, please describe and list the dates

Are you currently on any medications? Yes / No     If yes, please state the medication and the dosage________

Are you allergic to any types of food 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></td>
<td>Heart Disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td></td>
<td>High Blood Pressure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
<td>Mental Health Disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
<td></td>
<td>Substance Abuse (drug/alcohol)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
<td>Tuberculosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizures</td>
<td></td>
<td></td>
<td></td>
<td>Sickle Cell/ Anemia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Disease</td>
<td></td>
<td></td>
<td></td>
<td>Other</td>
<td></td>
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</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 N</th>
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<th>Y N</th>
<th></th>
<th>Y N</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety/Depression</td>
<td></td>
<td>Heart Disease</td>
<td></td>
<td>Substance Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td>Hepatitis/Jaundice</td>
<td></td>
<td>Thyroid Disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autoimmune disease (lupus)</td>
<td></td>
<td>High Blood Pressure</td>
<td></td>
<td>Tuberculosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleeding Disorder</td>
<td></td>
<td>High Cholesterol or lipid disorders</td>
<td></td>
<td>Physical Disability</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bone Joint problems</td>
<td></td>
<td>Kidney/Bladder Disease</td>
<td>ALLERGIES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td>Malaria</td>
<td></td>
<td>Penicillin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chicken Pox</td>
<td></td>
<td>Migraine /Severe Headaches</td>
<td>Sulfur</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Cough</td>
<td></td>
<td>Maternal Illness</td>
<td></td>
<td>Other Antibiotics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td>Polycystic Ovary Syndrome</td>
<td>Codeine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disabilities</td>
<td></td>
<td>Psychiatric Condition</td>
<td>Aspirin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating Disorder</td>
<td></td>
<td>Psychotherapy</td>
<td></td>
<td>Foods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female or Menstrual Problem</td>
<td></td>
<td>Recent unexplained Weight Change</td>
<td>Dust</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gum/Dental Disorder</td>
<td></td>
<td>Seizures/Blackouts</td>
<td>Wasp/Bee Stings/Fire Ants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head Injury</td>
<td></td>
<td>Sexually Transmitted Infections</td>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Impairment</td>
<td></td>
<td>Skin Disorders</td>
<td></td>
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</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 purposes.

I hereby acknowledge that I have read and understand the nature and conditions of this consent and release.

_____________________________    /_____/____/     _______________________________    /_____/_____/
Signature of Student                           Date                          Signature of Parent/    Date
Guardian if student under age 18
PART B – IMMUNIZATION RECORDS

IMMUNIZATIONS REQUIRED FOR STUDENTS ENTERING THE UNIVERSITY OF THE WEST INDIES TO BE COMPLETED AND SIGNED BY A HEALTHCARE PROVIDER

Please print in BLOCK letters

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
  - Dose 2: _____/_____/______mm/dd/yyyy
  (Given at age 12-15 months or later)

- 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

Signature of Healthcare Provider

Date

Printed Name or Office Stamp
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 ____/____/___
Last    First

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>NORMAL (✓)</td>
<td>ABNORMAL (✓)</td>
<td>COMMENTS</td>
<td></td>
<td></td>
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<tr>
<td>Head, Ears, Nose or Throat</td>
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<tr>
<td>Respiratory</td>
<td></td>
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<td>Cardiovascular</td>
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<tr>
<td>Gastrointestinal</td>
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<tr>
<td>Eyes (Refractive)</td>
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<tr>
<td>Eyes (Other)</td>
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<tr>
<td>Genitourinary</td>
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<td>Musculoskeletal</td>
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<td>Metabolic/Endocrine</td>
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<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>
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<tr>
<td>Vascular System</td>
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<tr>
<td>Endocrine System</td>
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<tr>
<td>Neurological System</td>
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<tr>
<td>Dental</td>
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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: _____/_____/______

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**SECTION3: PHYSICIAN VERIFICATION**

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<table>
<thead>
<tr>
<th>Name of Physician</th>
<th>Signature of Physician</th>
<th>Physician's Stamp</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>Address</th>
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</thead>
<tbody>
<tr>
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</table>

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<table>
<thead>
<tr>
<th>Medical Board Registration Number</th>
<th>Date</th>
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</table>