MEDICAL FORM

1. **TO BE FILLED IN BY THE APPLICANT WITH THE HELP OF A MEDICAL PRACTITIONER**

Name: ____

Birth Date: **Year:**_____________**Month:** ______________**Day:** ________________

Name of Parent/Guardian:______________________________________

Sex: Male ☐ **Female** ☐

Mailing Address:____

City: ____________ **Postal Code**: ________________**Country:** ______________

Home Phone: ___________________________**Mobile Phone:** __________________________

Fax: _______________________ **Email:** ___________________________

2. **HAVE YOU EVER HAD OR DO YOU SUFFER FROM**

	No	Yes	(If yes, When)		No	Yes	(If yes, When)		No	Yes	(If yes, When)
Chicken Pox	☐	☐	__________	**Diabetes**	☐	☐	__________	**Mental Illness**	☐	☐	__________
Rubella	☐	☐	__________	**Tuberculosis**	☐	☐	__________	**Eating Disorder**	☐	☐	__________
Measles	☐	☐	__________	**Hepatitis A/B/C**	☐	☐	__________	**Sleeping Disorder**	☐	☐	__________
Mumps	☐	☐	__________	**Epilepsy**	☐	☐	__________				

3. **PERSONAL MEDICAL HISTORY**

Do you have allergies (specify)____

Do you take medication on a regular basis?____

Have you ever had any operation?____

Are you on a special diet?____

Have you ever had any accident with mental or physical impairment? ____________________________

4. **Learning Support**

Do you have a learning difficulty, disability, mental health issues or medical condition? YES ☐ NO ☐

If 'yes' please outline your learning difficulty, disability, medical condition and/or health difficulty (this will not prejudice your application in any way).This information is needed to determine whether you will require any specific support during your studies.

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5. **DECLARATION**

I hereby certify that the above information is correct and that I agree to undergo a medical checkup if required to do so. I also declare that I will be responsible for the consequences of my eligibility to the applied course for giving false medical information.

Signature of applicant: ___________________________________ Date: _________________________

Signature of the parent or legal guardian: _________________Date:_____________________________

MEDICAL REPORT TO BE COMPLETED AT A REGISTERED MEDICAL CENTER, PLACED IN AN ENVELOPE, SEALED AND STAMPED

Name of the patient:

____

Date of Birth
Year:___________________Month: _________________Day: __________________

Blood pressure:_________MM/HG Height (cm)___________Weight (Kg)______Pulse rate_________

Please indicate your observation on each of the following areas:-

REQUIRED LABORATORY TESTS/INFORMATION

Please indicate if the patient has suffered/or is suffering from:-

	Yes	No	Dates of any doses	Doses
Tuberculosis (BCG)	☐	☐	____________	____________
Whopping Cough	☐	☐	____________	____________
Tetanus	☐	☐	____________	____________
Poliomyelitis	☐	☐	____________	____________
Diphtheria	☐	☐	____________	____________
Hepatitis A/B & C	☐	☐	____________	____________
Diabetes	☐	☐	____________	____________

Please indicate your observation on the general status of each of the following areas:-

1. Mouth & Throat ____________________
2. Eyes & Ears ____________________
3. Neck & Head ____________________
4. Skin Condition ____________________
5. Chests & Lungs ____________________
6. Heart & Blood Vessels ____________________
7. Digestive System ____________________
8. Nervous System ____________________
9. Skeletal, Muscular System ____________________
10. Urinary, Reproductive System ____________________
11. Others (Specify) ____________________

Other comments:____

GENERAL OBSERVATION AND DECLARATION BY DR/PHYSICIAN

I**,** Doctor ____________________ certify that the above information is correct, that the general state of health, physical and mental condition of the applicant is good and they can undertake training in a hospitality college.

Date: ______________ Doctor's Signature and Stamp: ____________________