MEDICAL FORM

1) TO BE FILLED IN BY THE APPLICANT WITH THE HELP OF A MEDICAL PRACTIONER

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?_____

Do you have learning problems?_____

Are you on a special diet?_____

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

4) 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 CENTRE, 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_____