SAMUEL JACKMAN PRESCOD INSTITUTE OF TECHNOLOGY
DIVISION OF STUDENT SERVICES

MEDICAL FORM

You must complete this Medical Form and email it to studentservices@sjpi.edu.bb in the Division of Student Services at the Samuel Jackman Prescod Institute of Technology by the time of Registration, **Friday, August 28, 2020**.

Part A is to be completed and signed by the applicant and Part B is to be signed by the registered Medical Practitioner who has examined the applicant.

PART A

STUDENT NAME: _____

STUDENT NUMBER: _____

PROGRAMME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

MEDICAL HISTORY

NAME OF PRIMARY PHYSICIAN: _____

ARE YOU CURRENTLY USING MEDICATION? PLEASE TICK☑: YES ☐ **NO** ☐

IF YES, PLEASE STATE THE PURPOSE AND NAME OF THE MEDICATION:

_____

_____

STATE ANY MEDICAL CONDITION(S). PLEASE TICK ☑ THE APPROPRIATE BOX BELOW:

ALLERGIES	☐	ASTHMA	☐	DIABETES	☐
EPILEPSY	☐	FAINTING	☐	HYPERTENSION	☐
MENTAL HISTORY	☐				

STATE ANY PHYSICAL OR PSYCHOLOGICAL DISORDER OR DISABILITY INCLUDING DYSLEXIA (GIVE DETAILS):

_____

_____

_____ _____

SIGNATURE **DATE**

PART B

IMMUNISATION VERIFICATION FORM

(TO BE COMPLETED BY PHYSICIAN. All boxes MUST be completed.)

Please indicate below any conditions you consider significant:

MEDICAL HISTORY	NO	YES	DETAILS
Is there any abnormality on general physical examination including investigations on urine tests, blood tests X-rays and ECG?			
Is there any physical or mental disability, which can potentially affect the candidate in his/her studies?			
Is there a history of allergies to drugs such as penicillin, aspirin or allergic conditions such as asthma, eczema, food?			
Is there any evidence of recent infectious disease?			
Has the candidate been treated for any of the following? Asthma, epilepsy, diabetes, hypertension, other chronic illness			

IMMUNISATION HISTORY	
IMMUNISATIONS AGAINST	**DATES (PHYSICIAN VALIDATED DATE OF VACCINATION)**
Tetanus, Diphtheria and Pertussis	DPT:
Measles, Mumps, German (Rubella)	MMR 1: MMR 2:
Poliomyelitis	OPV/IPV:
Hepatitis B **(Required by Nursing Auxiliary Studies, Hairdressing Skills and Esthetics students ONLY)**	1ST DOSE 2ND DOSE (4 weeks after) 3RD DOSE (6 months after)
Varicella (Without Evidence of Immunity) **(Required by Nursing Auxiliary students ONLY)**	1ST DOSE 2ND DOSE (4 weeks after)

PHYSICIAN'S NAME: _____

ADDRESS: _____

TELEPHONE: _____

_____ _____

PHYSICIAN'S SIGNATURE **DATE**

STAMP HERE