UNIVERSITY HEALTH CENTRE (HEALTH SERVICE)

Admission Medical Examination Report - Graduate Students (Local and International)

PART I (Personal Particular to be completed by Student)

Full Name: _____ Gender: Male / Female
(underline Surname / Family Name)

Course of Study: _____ Email Address: _____

NRIC / Passport No: _____ FIN No: _____

Date of Birth: _____ Nationality (citizenship status): _____

Home Address: _____

Tel No (Handphone): _____ (Home): _____

In case of emergency, person to contact: _____ Relationship: _____

Person's Contact No: _____ Email Address: _____

1) Are you currently under treatment or have been treated for any long-term physical condition?

☐ **No** ☐ **Yes**

*If "**Yes**", please provide details.*

_____

_____

2) Are you currently under treatment or have been treated by a psychiatrist, clinical psychologist, or other mental health professional?

☐ **No** ☐ **Yes**

*If "**Yes**", please provide details (diagnosis, treatment, date and duration, etc – Please use a separate sheet if necessary).*

_____

_____

Personal Medical History:

Have you suffered from or undergone any of the following?

(Please *Tick* [✓] No or Yes. If "***Yes***" please specify condition and duration.)

	No	Yes	Details
Allergies			
Acute/Chronic Respiratory Disorders			
Blood Disorders			
Gastro-intestinal Disorders			
Heart Disorders			
Injuries or Deformities			
Kidney / Urinary Disorders			
Muscular / Joint Disorders (e.g. scoliosis)			
Skin Disorders			
Surgical Procedures			
Any other conditions (e.g. Hepatitis B Carrier, G6PD deficiency, menstrual disorders)			

I hereby certify that the answers given by me to the above listed questions are correct and true. I understand that NUS at its discretion, can choose not to bear costs of any future medical impairment, illness, treatment or investigation that may arise, should there be false or incomplete declaration made on the above. I have no objection to the release of my medical report(s) from the hospital(s) or doctor(s) concerned, if necessary.

I hereby consent to NUS collecting and using the information I have provided herein for the purposes of evaluating my admission to NUS. Further, I hereby consent to NUS disclosing the information provided herein to NUS' insurers for the purposes of the insurers assessing my eligibility for insurance coverage.

Signature of Student: _____ Date: _____

PART II (Medical Examination)

(Note: To be completed by a registered physician who is not a relative of the student being examined)

Student's Full Name: _____ NRIC / Passport No: _____
(underline Surname / Family Name)

Height: _____ m Weight: _____ kg

Blood Pressure: _____/_____ mmHg Pulse Rate: _____ per minute ☐ Regular ☐ Irregular

Visual Acuity: Uncorrected: Right: 6 / ____ Left: 6 / ____ Colour Vision: ☐ Normal ☐ Abnormal

Corrected: Right: 6 / ____ Left: 6 / ____

Please examine the following systems and indicate any abnormalities:
(Please *Tick* [✓] whichever is applicable and provide details if response is ***Abnormal***.)

	Normal	Abnormal	Details
Eyes (other than myopia)			
Respiratory			
Cardiovascular			
Gastro-Intestinal			
Muscular/Skeletal			
Neurological			
Psychiatric			
If any other conditions, please indicate here:			

Laboratory Examination (Please Tick [✓] whichever is applicable):

		Negative	Positive	Value		
Urinalysis Test Date: _____	Albumin:				**Urine FEME** (If Indicated) Test Date: _____	Sugar _____ Protein _____ pH _____
	Sugar:					RBCs _____ /µL WBCs _____ /µL ECs _____ /µL
	Red Blood Cells:					Casts _____ Crystals _____ Organisms _____
						Trichomonas _____ Occult Blood _____
Others (If Indicated)						Reference Ranges: RBCs 0 – 3/µL, WBCs 0 – 6/ µL

Radiological Examination of the Chest *(*Please indicate the X-RAY findings with a ✓):
(Please attach a copy of the Chest X-ray report together with this form to University Health Centre. The X-ray report must be ***in English*** with student's name and identity no. or date of birth.)

Normal	Abnormal	Remarks	Date of X-ray

CONCLUSION *(*Please conclude and indicate if student is fit for studies at NUS with a ✓):

FIT	UNFIT	Date of Examination

Physician's Comments (if applicable): _____

Physician's Name & Stamp :	Signature:	Clinic Stamp and Address: