BAHAMAS TECHNICAL & VOCATIONAL INSTITUTE
MEDICAL RECORD

Please return this form in a sealed envelope marked **`MEDICAL RECORD'**
To: THE ADMISSION OFFICE, BAHAMAS TECHNICAL & VOCATIONAL INSTITUTE

PART A: GENERAL INFORMATION
TO BE COMPLETED BY APPLICANT, APPLICANT'S PARENT OR GUARDIAN

LAST NAME FIRST NAME MIDDLE NAME

ADDRESS (Street Name) HOUSE#

P.O.BOX TELEPHONE (HOME) (WORK)

DATE OF BIRTH:_____/___/_____ AGE:_______ SEX:MALE[ ] FEMALE[ ]

STUDENT NUMBER:______________ SEMESTER:____________ YEAR ENTERING BTVI______

MARITAL STATUS: MARRIED[ ] SINGLE[ ] DIVORCED[ ]

PERSON TO NOTIFY IN CASE OF EMERGENCY RELATIONSAHIP

STREET ADDRESS TELEPHONE (HOME) (WORK)

FAMILY MEDICAL HISTORY

Has any of your immediate family had any of the following?

Tuberculosis	Yes[ ]	No[ ]	Diabetes	Yes[ ]	No[ ]
Heart Disease	Yes[ ]	No[ ]	Cancer	Yes[ ]	No[ ]
High Blood Pressure	Yes[ ]	No[ ]	Emotional Disorders	Yes[ ]	No[ ]

Other (please specify)____

PERSONAL HEALTH HISTORY

ALLERGIES TO: FOOD (List them)____

DRUGS (List them)____

MEDICINES ROUTINELY TAKEN:____

HAVE YOU HAD OR SOUGHT MEDICAL ASSISTANCE FOR ANY OF THE FOLLOWING?

Asthma	Yes[ ]	No[ ]	Pneumonia	Yes[ ]	No[ ]
Diabetes	Yes[ ]	No[ ]	Prolonged Depression	Yes[ ]	No[ ]
Heart Disease	Yes[ ]	No[ ]	Rheumatic fever	Yes[ ]	No[ ]
Hepatitis	Yes[ ]	No[ ]	Ulcers	Yes[ ]	No[ ]
High blood pressure	Yes[ ]	No[ ]	Urinary infections	Yes[ ]	No[ ]
Kidney Disease	Yes[ ]	No[ ]	Venereal disease	Yes[ ]	No[ ]
Severe menstrual cramps	Yes[ ]	No[ ]			

LIST ANY MAJOR ILLNESS____

LIST ANY MAJOR SURGERY____

PART B:
TO BE COMPLETED BY YOUR PERSONAL PHYSICIAN

PLEASE TICK IF Normal; If Abnormal, please state Problem(s) in space provided:

Eyes	[ ]	Heart	[ ]	Skin	[ ]	Temperature	[ ]
Ears	[ ]	Vascular	[ ]	Lymph Nodes	[ ]	Pulse	[ ]
Nose	[ ]	Lungs	[ ]	Muscular/Skeletal	[ ]	Respiration	[ ]
Mouth	[ ]	Breast	[ ]	Nutrition	[ ]	B/P	[ ]
Throat	[ ]	Abdomen	[ ]	Neurological	[ ]	Height	[ ]
Thyroid	[ ]	Genitalia	[ ]	Spine	[ ]	Weight	[ ]
Chest	[ ]	Rectal	[ ]	Vision	[ ]	Urine	[ ]

Handicap (phy./other) [ ]   Behavior [ ]   Stool [ ]

Abuse (Substance/phy./emotional) [ ]

Problems: ____

____

____

BLOOD INVESTIGATIONS

FBC:__________________   Hb:__________________

Assessment____

Mantoux-Date Given: _____/_____/______ (dy. mo. yr.)   Results:__________________

Chest X-ray(If Mantoux pos.) ______________   Results: __________________

REQUIRED IMMUNIZATION (Please update P.R.N.)

D.P.T.. Primary series completed ____/____/____ (dy. mo yr)   POLIO: Primary series completed ____/____/____ (dy. mo yr)

Last D.T. BOOSTER ___/____/_____ (dy. mo yr)   (Repeat If over 10 years duration) ____/____/____ (dy. mo yr)

MMR. VACCINE-1st Dose ____/____/____ (dy. mo yr)   2nd Dose ____/____/____ (dy. mo yr)

MEASLES VACCINE ___/____/_____ (dy. mo. yr.)   RUBELLA VACCINE ____/____/____ (dy. mo. yr.)

NOTE: A: ALL STUDENTS 40 YEARS AND UNDER ARE REQUIRED TO HAVE: EITHER 2 DOSES OF MMR OR 1 DOSE OF MMR PLUS 1 DOSE OF MEASLES AND 1 DOSE OF REBELLA VACCINE.

B: ALL STUDENT MUST PRESENT EVIDENCE OF A COMPLETED D.T. BOOSTER WITHIN THE LAST TEN YEARS.

1. ______________________ PHYSCIAN'S NAME (Please Print)   ______________________ Physician's Signature   _____/____/_____ dy. mo. yr.
2. ____ BUSINESS ADDRESS OF PHYSICIAN:
3. ______________________ TELEPHONE