# BAHAMAS TECHNICAL & VOCATIONAL INSTITUTE
## MEDICAL RECORD

Please return this form **dated, signed and stamped** from a Medical Doctor in a sealed envelope marked **`MEDICAL RECORD' To: THE ADMISSIONS 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 ☐

______________________________________________________________________
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**

Other Medical Conditions:___________________________________________

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: 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 | [ ] |
| Behavior | [ ] | Stool | [ ] | | | | |

Abuse (Substance/Physical/Emotional)

Disabilities:

Other Medical Conditions:____________________________________________________________

Problems: ___________________________________________________________________

______________________________________________________________________________

**BLOOD INVESTIGATIONS**

FBC:__________________________________ Hb:__________________________________

Assessment____________________________________________________________________

Mantoux-Date Given: ______/______/______ Results:______________________________
MM DD YY

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

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

**D.P.T. Primary series completed** _____/_____/______
**MM DD YY**

**Last D.T. BOOSTER** _____/_____/______
**MM DD YY**

**MMR. VACCINE - 1st Dose** _____/_____/______
**MM DD YY**

**MEASLES VACCINE** _____/_____/______
**MM DD YY**

**POLIO: Primary series completed** ______/_____/______
**MM DD YY**

**(Repeat If over 10 years duration)** ______/_____/______
**MM DD YY**

**2nd Dose** ______/_____/______
**MM DD YY**

**RUBELLA VACCINE** ______/_____/______
**MM DD YY**

**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 MM DD YY

2. ______________________________________________________________________
BUSINESS ADDRESS OF PHYSICIAN:

3. ____________________________
TELEPHONE

*(Medical Practitioner's Stamp)*