SATHYABAMA
INSTITUTE OF SCIENCE AND TECHNOLOGY
(DEEMEND TO BE UNIVERSITY)
(Established under Section 3 of the UGC Act, 1956)
Accredited with 'A' Grade by NAAC
Rajiv Gandhi Road,Jeppiaar Nagar Chennai – 600 119, Tamilnadu. India.
Centre for Academic Partnership and International Relations

MEDICAL EXAMINATION GUIDELINES FOR INTERNATIONAL STUDENTS

1. PLEASE READ THE INSTRUCTIONS CAREFULLY BEFORE FILLING IN THE FORM.
2. PLEASE FILL IN THE FORM IN **ENGLISH** LANGUAGE.
3. PLEASE WRITE IN **CAPITAL LETTERS**.
4. THIS FORM HAS **4 SECTIONS :**
   (A) SECTION 1 (PART A & B) TO BE FILLED BY THE CANDIDATES; AND
   (B) SECTION 2,3 & 4 TO BE FILLED BY THE EXAMINING DOCTOR
5. PLEASE COMPLETE ALL THE TESTS REQUIRED IN THIS FORM.
6. THE UNIVERSITY ONLY ACCEPTS MEDICAL EXAMINATION DONE WITHIN **60 DAYS** BEFORE REGISTRATION.
7. PLEASE ATTACH ALL THE **ORIGINAL** LABORATORY RESULTS.
8. PLEASE BRING ALONG THE **CHEST X-RAY FILM AND REPORT** FOR REGISTRATION.
9. PLEASE ENSURE THE X-RAY FILM IS **LABELLED** WITH YOUR NAME AND DATE TAKEN (IN ENGLISH)
10. THE UNIVERSITY RESERVES THE RIGHT TO **REPEAT FULL** MEDICAL CHECK-UP OR ANY SPECIFIC LABORATORY TESTS SHOULD THERE BE ANY DOUBT IN THE MEDICAL REPORT SUBMITTED. ALL COSTS INVOLVED SHALL BE BORNE BY THE CANDIDATES.
11. THE UNIVERSITY RESERVES THE RIGHT TO REJECT ANY APPLICATION;
    (A) BASED ON THE RESULTS OF THE HEALTH EXAMINATION; OR
    (B) SHOULD THERE BE ANY EVIDENCE THAT THE APPLICANT HAS GIVEN FALSE INFORMATION IN THE HEALTH EXAMINATION REPORT OR ANY SUPPORTING DOCUMENTS.

SATHYABAMA INSTITUTE OF SCIENCE & TECHNOLOGY

MEDICAL EXAMINATION REPORT FOR INTERNATIONAL STUDENT

Passport Size Photo

PLEASE USE CAPITAL LETTERS

SECTION 1 (To be completed by candidate)

PART A

FULL NAME (AS IN PASSPORT)

INTERNATIONAL PASSPORT NO.

NATIONALITY **CONTACT NUMBER**

DATE OF BIRTH **AGE** **SEX** **MARITAL STATUS**

D D M M Y Y

MALE
FEMALE

SINGLE
MARRIED

ACADEMIC YEAR **PROGRAMME CODE** **SEMESTER**

/

PROGRAMME OF STUDY **MATRIC NO.**

NEXT OF KIN

NEXT OF KIN'S ADDRESS

NEXT OF KIN'S CONTACT NUMBER

SECTION 1

PART B – Please tick (√) in the relevant box.

Declaration of self and family illness. Explain in full if you or your family has any of the following illnesses. * Immediate family refers to father, mother, brothers / Sisters.

MEDICAL PROBLEMS	SELF		IMMEDIATE FAMILY		If "Yes" please state.
	Yes	No	Yes	No	
1. Congenital or inherited disorder					
2. Allergy					
3. Mental illness					
4. Fits, stroke, other neurological disease					
5. Diabetes Mellitus					
6. Hypertension					
7. Heart or vascular disease					
8. Asthma					
9. Thyroid disease					
10. Kidney disease					
11. Cancer					
12. Tuberculosis					
13. Drug Addiction					
14. AIDS, HIV					

15.	History of Surgery					
16.	Other illnesses					

Current medication (Long term)

_____ _____

_____ _____

IMMUNIZATION HISTORY (where applicable)		DATE IMMUNIZED				
1.	Yellow Fever					
2.	BCG					
3.	Meningitis (Quadrivalent)					
4.	Hepatitis B					
5.	Others :					

I hereby certify that the information given above is true. I understand that my application will be rejected if there is any false information given

_____ _____

Date Signature of Candidate

SECTION 2 PHYSICAL EXAMINATION

–

To be filled by examining doctor

1. BASIC MEASUREMENT	
HEIGHT : _____ m	BLOOD PRESSURE : _____ mmHg
WEIGHT : _____ kg	PULSE RATE : _____ / min
VISION TEST : Unaided : (R) _____ (L) _____ Aided : (R) _____ (L) _____	COLOUR VISION TEST : NORMAL / ABNORMAL

2 GENERAL EXAMINATION

.

ITEM	**YES**	**NO**	**COMMENT**
a. DEFORMITIES			
b. PALLOR			
c. CYANOSIS			
d. JAUNDICE			
e. OEDEMA			
f. SKIN DISEASE			

3. SYSTEM EXAMINATION

ITEM	**NORMAL**	**ABNORMAL**	**COMMENT**
a. EYES (including funduscopy)			
b. EARS			
c. NOSE			
d. ORAL CAVITY / THROAT			
e. NECK			
f. HEART			
g. LUNGS			
h. ABDOMEN / HERNIA ORIFICES			
i. NERVOUS SYSTEM			
j. MENTAL CONDITION			
k. MUSCULOSKELETAL SYSTEM			

SECTION 3 - INVESTIGATIONS

URINE TEST

ITEM	DATE TAKEN	RESU
		LT
a. ALBUMIN		
b. SUGAR		
c. MICROSCOPIC		

d. MORPHINE

e. CANNABIS

f. AMPHEYAMINES TYPE STIMULANT

BLOOD TEST		
ITEM	DATE TAKEN	RESU
		LT
a. HEPATITIS Bs ANTIGEN		
b. HEPATITIS C		

c. HIV

d. VDRL / TPHA

e. MALARIAL PARASITE

CHEST X-RAY INFORMATION	
CHEST X-RAY NO.	
DATE TAKEN	
PLACE TAKEN	
REPORT	

SECTION 4 - CERTIFICATION BY THE EXAMINING DOCTOR

Please tick (√) in the appropriate box

I certify that I have on this date _____ examined Mr / Ms_____

Passport No. _____ and found him / her :-

☐ IN GOOD HEALTH

☐ HAS MEDICAL PROBLEM (Please State)

_____

_____

_____

☐ IS UNDERGOING TREAMENT FOR: (Please State)

_____

_____

_____

Date: _____

Signature of Doctor : _____
Name of Doctor : _____
Qualification and : _____
Official stamp of Clinic

Remarks By University Official: