



SATHYABAMA

INSTITUTE OF SCIENCE AND TECHNOLOGY (DEEMED 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.

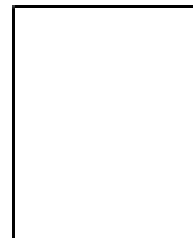


Centre for Academic Partnership and International Relations

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.

MEDICAL EXAMINATION REPORT FOR INTERNATIONAL STUDENT

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NEXT OF KIN'S CONTACT NUMBER

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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 .					
1 Kidney disease 0 .					
1 Cancer 1 .					
1 Tuberculosis 2 .					
1 Drug Addiction 3 .					
1 AIDS, HIV 4 .					

1	History of Surgery					
5						
.						
1	Other illnesses					
6						
.						

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 TREATMENT FOR: (Please State)

Date: _____

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

Remarks By University Official:

