UMHS
UNIVERSITY OF MEDICINE AND HEALTH SCIENCES

OFFICE OF ADMISSIONS
admissions@umhs-sk.net
phone: 212-868-0855
fax: 212-868-4722

Medical Examination Form

University of Medicine and Health Sciences, St. Kitts

**** USE BLACK INK ONLY ****
PHYSICAL EXAMINATION (must be completed by Physician)

Date: _____

Name: _____ **Phone #:** _____
Address: _____**City:** _____ **State:** _____**Zip:** _____
Country: _____**Citizenship:** _____**EMail:**_____

Person to be notified in case of emergency (include all contact numbers and e-mail addresses):

_____

Passport #/expiration date (please state nationality)

_____

Past medical/surgical history: (note all hospital admissions within last 5 years) _____

_____

Has the student suffered from Psychological/Mental illness in the past year? **Yes / No**
If so, please give account: _____
Allergies/state all medications _____

Height: _____(without shoes) **Weight:** _____ **Nose:** _____ **Throat:** _____
Ears: _____ **Temp:** _____ **Pulse:** _____ **Resp:** _____ **Blood Pressure:** _____
Lungs: _____ **Heart:** _____ **Neuro:** _____

Extremities: _____ **Abdomen:** _____ **Gu/Gyn:** _____
PPD/Mantoux (TB): Date _____**Result:** _____
If positive PPD, did you find any evidence of disease? Yes ___ No ___ Chest X-Ray Date: _____
Interpretation: _____ Prophylactic Rx: _____

Tetanus (within 10 yrs.): _____**VDRL/RPR** (mandatory): _____ **COVID 19** Vaccination Date _____
Rubella (German measles) Titer: _____Date _____ **Rubeola** (Measles) Titer: _____ Date _____
Mumps Titer: _____ **Varicella** Titer: _____ Those with negative Varicella Titer need proof of immunizations/dates of Viravax: _____ **Polio** immunization/Titer _____ Date _____

* **Evidence of Vaccination for DTP, Rubeola, Rubella, Mumps, Varicella, Hepatis B, Polio & COVID 19 is MANDATORY**

Hepatitis B Vaccine Dates: (Mandatory)
Dates: 1. _____ 2. _____ 3. _____
If there is any reason why an immunization cannot be given, please specify in writing:
_____
Urine test result for "Routine Drug Screening" (Interpretation by primary care provider).
_____

PHYSICIAN: I, _____, have given a complete physical examination to _____ and in my opinion feel she/he is in _____ physical and mental health and is capable of participating without hazard in clinical practice settings.
Primary Care Provider Signature _____
Address: _____ **Phone #**: _____
STUDENT: I, the undersigned, give my permission to have my medical records released to the affiliating agency(s). As requested, I also verify that health and evacuation insurance is up to date and current.
STUDENT'S SIGNATURE _____**DATE** _____