MEDICAL REPORT

SPECTRUM FILM SCHOOL

MAKING LEARNING FUN

MEDICAL REPORT

SPECTRUM FILM SCHOOL

STUDENTS MEDICAL EXAMINATION FORM

TO BE FILLED IN BY THE APPLICANT WITH THE HELP OF A CERTIFIED GOVERNMENT MEDICAL PRACTIONER

PERSONAL INFORMATION

Name

Date of Birth

Phone Number

Email

Address

Nationality

City

Postal Code

Country

Sex Male ◯ Female ◯

PARENT & GUARDIAN INFORMATION

Name

Phone Number

HAVE YOU HAD ANY OF THE FOLLOWING ILLNESSES

	No	Yes		No	Yes
Tuberculosis	◯	◯	*Mental Illness*	◯	◯
Hepatitis A/B/C	◯	◯	*Epilepsy*	◯	◯
Diabetes	◯	◯	*Covid 19*	◯	◯
Heart Disease	◯	◯	*Poliomyelitis*	◯	◯

If the answer to any of the above is Yes, please give details with dates

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PERSONAL MEDICAL HISTORY

Do you have allergies? (If yes, Specify)

Do you take medication on a regular basis ? (If yes, Specify)

Do you have learning problems? (If yes, Specify)

Do you have any special dietary requirements? (If yes, Specify)

Have you ever had any accident with mental or physical impairment?

HAVE YOU BEEN IMMUNIZED AGAINST

	No	Yes		No	Yes
Tuberculosis	◯	◯	*Small pox*	◯	◯
Covid 19	◯	◯	*Measles*	◯	◯
Poliomyelitis	◯	◯	*Tetanus*	◯	◯

DECLARATION

I hereby certify that the above information is correct and that I agree to undergo a medical checkup if required to do so. I also declare that I will be responsible for the consequences of my eligibility to the applied course for giving false medical information.

Date

Signature of applicant

Date

Signature of the parent or guardian

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EXAMINING MEDICAL OFFICER

TO BE COMPLETED BY A REGISTERED MEDICAL CENTRE, SIGNED AND STAMPED, SCANNED AND UPLOADED DURING APPLICATION

PATIENT INFORMATION

Name of the patient

Date of Birth

Blood pressure (mmHg)

Height(cm)

Weight(Kg)

Pulse rate

REQUIRED LABORATORY TESTS

INDICATE THE STATUS OF RESULTS OF THE FOLLOWING

	No	Yes	Dates	Doses
Tuberculosis	○	○		
Whopping Cough	○	○		
Tetanus	○	○		
Poliomyelitis	○	○		
Diphtheria	○	○		
Hepatitis A/B & C	○	○		
Diabetes	○	○		

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INDICATE YOUR OBSERVATION ON THE FOLLOWING

	No	Yes	Observation
Mouth & Throat	◯	◯	
Eyes & Ears	◯	◯	
Neck & Head	◯	◯	
Skin Condition	◯	◯	
Chests & Lungs	◯	◯	
Heart	◯	◯	
Blood Vessels	◯	◯	
Digestive System	◯	◯	
Nervous System	◯	◯	
Skeletal System	◯	◯	
Muscular System	◯	◯	
Urinary System	◯	◯	
Reproductive System	◯	◯	
Others (Specify)	◯	◯	

Other comments

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EXAMINING MEDICAL OFFICE'S DECLARATION

I, Doctor _____ *certify that the above information is correct, that the general state of health, physical and mental condition of the applicant is good and can undertake training in a TVETA Institution.*

Date

Doctor's Signature and Stamp