**University of Doha For Science & Technology (UDST)**

**College of Health Sciences (CHS)**

**CONFIDENTIAL Student Medical Assessment Form**

This medical form must be completed by all students accepted into any of the College of Health Sciences programs including Medical Radiography, Respiratory Therapy, Practical Nursing, Midwifery, Paramedicine, Dental Hygiene, Pharmacy Technology, and Environmental Health (when required). Please read the instructions carefully before completing the form.

Students *will not be permitted* to attend clinical/work term courses until this form has been completed and submitted to the program practice lead at the College of Health Sciences.

UDST assumes no financial responsibility for the completion of this form and/or necessary diagnostic tests/reports.

ONCE COMPLETED, KEEP A COPY OF THIS FORM FOR YOUR RECORDS

**To be completed by the student prior to physician assessment:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Program: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release of Information** (Please sign before your physical examination)

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, consent to have this medical information released to the University of Doha for Science & Technology and if required to our Healthcare facility affiliates.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**All sections must *be completed by a physician***

**Section 1: Physical Examination:**

|  |
| --- |
| **This section must be completed by a qualified healthcare provider (QCHP registered & licensed)** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Physical Exam abnormal findings** | **Yes** | **No** | **If yes, please specify** |
| ENT (e.g., Hearing impairment) |  |  |  |
| Heart (e.g., BP problems) |  |  |  |
| Respiratory System |  |  |  |
| Abdomen |  |  |  |
| Genitourinary System (e.g., Kidney) |  |  |  |
| Nervous System |  |  |  |
| Endocrine System |  |  |  |
| Allergies |  |  |  |
| Impaired Vision/color blindness |  |  |  |
| Special Needs |  |  |  |

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 2: Communicable Disease/Immunization Record/Screening Report**

***You must provide a copy of all serology reports***

|  |  |  |
| --- | --- | --- |
|  | DATE (year/month/day) | RESULTS |
| Chest X-Ray |  |  |
| HIV |  |  |
| Hepatitis C |  |  |
| Hepatitis B Screening (HBsAG) |  |  |
| Hepatitis B antibody (HbsAb) (*titer and immunity level*) |  |  |

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| TB Screening and PPD | Date (year/month/day) | Results |
| Mantoux  (two steps are required if status unknown) | First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_  Second: \_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_ mm of induration  \_\_\_\_\_ mm of induration |
| Quantiferon (if required) |  |  |

|  |  |  |
| --- | --- | --- |
| Immune Status | Date (year/month/day) | Immune/Non-immune |
| Rubella |  | Immune\_\_\_  Non-Immune\_\_\_\_ |
| Measles |  | Immune\_\_\_  Non-Immune\_\_\_\_ |
| Mumps |  | Immune\_\_\_  Non-Immune\_\_\_\_ |
| Varicella |  | Immune\_\_\_  Non-Immune\_\_\_\_ |
| Tetanus/Diphtheria (Pertussis) [Td/T-dap] |  | Immune\_\_\_  Non-Immune\_\_\_\_ |

|  |  |
| --- | --- |
| Immunization | DATE (year/month/day) |
| Td (every 10 years) |  |
| MMR (include all dates) |  |
| Hepatitis B (include all dates) |  |
|  |
| Optional/ If required by the facility | |
| Flu vaccination (For Nursing and Midwifery Program/ program specific) |  |

Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_