REMARKS

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PHYSICAL HEALTH ______________________________

Is the trainee able to perform all normal duties Yes ☐ No ☐

(If no, Please explain) ______________________________

____

Doctor's Name ______________________________

Address ______________________________

____

Signature ____________________ Date ____________

HEART TRUST/NTA
TRAINEE MEDICAL REPORT

SECTION1: TO BE COMPLETED BY TRAINEE

Mr./Mrs/Miss ______________________________

Address: ______________________________

______________________________ Telephone #: ____________

Date of Birth: ________________ ID# ____________________

Institution: ________________ Res. ☐ Non-Res. ☐ Entry date: ______

# of Children: ________________ Age Range: ____________

In case of emergency contact:

Mr./Mrs./Miss: ______________________________

Address: ______________________________

______________________________ Telephone #: ____________

Next of Kin: ______________________________

Address: ______________________________

______________________________ Telephone #: ____________

Private and Confidential

<u>Past health – Please indicate those you have had</u>

Fits☐ Measles☐ Mumps☐ Polio☐ Typhoid Fever☐
Kidney Disease ☐ Rheumatic Fever ☐ Serious Illness ☐ Serious Injury ☐

If yes, give brief history ____
____

Present Condition	Self	Father	Mother	Relatives
Fits	_____	_____	_____	______
Polio	_____	_____	_____	______
Allergy	_____	_____	_____	______
Asthma	_____	_____	_____	______
Diabetes	_____	_____	_____	______
Mental Illness	_____	_____	_____	______
Heart Disease	_____	_____	_____	______
High Blood Pressure	_____	_____	_____	______
Drug Addiction	_____	_____	_____	______
Sickle Cell Disease	_____	_____	_____	______
Tuberculosis	_____	_____	_____	______
Migraine	_____	_____	_____	______
Other	_____	_____	_____	______

Present Health – Check any present symptoms

Difficulty: Seeing ☐ Hearing ☐
Chest: Cough ☐ Pain ☐ Spitting Blood ☐ Short of Breath ☐
Heart: Palpitation ☐ Chest Pain on Exertion ☐ Other ☐
Digestion: Heart Burn ☐ Vomiting or Passing Blood ☐ Ulcer ☐
Urinary: Burning ☐ Frequency ☐
Genitalia: Discharge ☐ Rash ☐ Period Pain ☐ Syphilis ☐
Gonorrhoea ☐ Genital Herpes ☐
Skin: Rashes ☐ Itching ☐ Dryness ☐
Emotional: Depression ☐ Anxiety ☐ Nervous ☐ Tension Headaches
Surgery: Yes ☐ No ☐ If Yes – Date_____ Type: Major ☐ Minor ☐

IMMUNIZATION STATUS – Fully ☐ Partially ☐ None
Do you possess a valid Food Handlers Permit? Yes ☐ No ☐

I hereby certify that all information stated and supplied by me to the Medical Examiner is correct. I further understand that any false information will render this document null & void and will cancel my entry to the Institution/Project.

Signature _______________________________ Date ______________________
____

SECTION 2

TO BE COMPLETED BY A MEDICAL PRACTITIONER

HEIGHT	WEIGHT	B/P	PULSE	MUCOSA

Eye (Vision/Pupils) Left___________________________________
Right___________________________________
Ears (Hearing) Left___________________________________
Right___________________________________

Mouth –Teeth_____________________ Nose/Sinuses______________________

Throat___________________________ Neck – Thyroid____________________

Heart ____________________________ Lungs__________________________

Abdomen: Masses – Type? ____

Pregnancy – Stage _______________________________________

L.M.P. ___________________________

Skin Rash & Infection ________________ Musculo-Sketal System ___________

Reflexes ________________________ Deformities ______________________

Urine	PH	Albumin	sugar

Blood Test Where App: Done ☐ Recorded Attached ☐ Not Done ☐