Tibetan Schoalrship Program

241 E 32nd Street
New York, NY - 10016

Tibetan Scholarship Program: Medical Certificate

Name: ____ Age: ___ ___ Sex: M / F
Date of Birth: __ __ / __ __ / __ __ __ __ Tel. #: ______________________ E-mail: __________________________

In Case of Emergency, Please notify

Name: ____ Relationship:_________________
Address: ____
____

Tel. #: ______________________________________ E-mail address: ____

Immunizations required before completion of Registration

Most American Universities require proof of immunization against MMR for all students. This immunization can be shown by the validated record of a physician or clinic. Please have physician validate this form or attached calidated copy of your medical sheet.

REQUIRED IMMUNIZATION Enter the month and year for each dose received	Series		Booster	
	Month	Year	Month	Year
1. Measles (7 day, Hard, Rubella)				
2. Rubella (3-day, German Measles)				
3. Diphtheria-Tetanus-Pertussis (DPT) - or Diphtheria-Tetanus - (DT) or (TD)				

IMMUNIZATION SCHEDULE

(A) One dose of live measles vaccine given after the first birthday and Dec. 1967 or a history of the disease diagnosed by a physician.
(B) One dose of live rebella vaccine given after the first birthday and Dec. 1967.
(C) Series of 4 doses of DTP or DT: with one booster dose every 10 years.
NOTE: MMR vaccine (Measles, Mumps and Rubella is the equivalent for Nos 1,2 and 5.
Enter date given

4. Skin Testing for Tuberculosis (Within 3 months of enrolling). Have your recevied BCG? Yes : ___ No: ____
   Please indicate which test and results PPD __, Chest X-Ray ___, or PPD Or Chest X-Ray: Date Given _______ Result: _____

	Series		Booster	
	Month	Year	Month	Year
5. Polio (Oral, Trivalent TOPV)				
6. Mumps				

To the best my knowledge, this person has received all the above immunizations. (Past immunizations may be validated from acceptable documents)

Signed: ____ Dated: __ __ / __ __ / __ __ __ __
Physician, Health Agency, or School

Do you have a handicap: Yes:__ No:__ Type of handicap________________________________ Attended Needed? Yes: __ No: __
Please indicate any allergies you have to foods, drugs, cosmetics, pollen, etc. ____
Explain nature of reaction (Hives, nausea, seizures, etc.) ____

Family History: Please indicate the disorders and family relationship:

Disorder	Relationship and age of onset	Disorder	Relationship and age of onset
Diabetes		Cancer	
Migrane Headches		Heart Attack / Stroke Under Age 60	
Blood Disease		Ulcers, Bowel or Intestinal Problem	
High Blood Pressure		Alcoholism	

Have you ever had or have now? Please circle

High Blod Pressure
Heart Trouble
Elevated Cholestrol or Blood Lipids
Rheumatic Fever
Lung Disorders
Asthma
Pneumonia
Chronic Cough: Bronchitis
Tuberculosis
Positive TB Test
Anemia
Hemophillia
Sickle -Cell Disease
Other Blood Disroder
Diabetes

Malaira
Measlesm (Germna per 3 day)
Measles (7- day or Hard)
Mumps
Whooping Cough
Scarlet Fever
Chicken Pox
Infectious Mononucleosis
Cerebgral (Brain) Concussion
Frequent or Severe Headches
Dizziness / Fainting Spells
Severe Head Injury
Paralysis
Epilepsy
Depression of Serious Nature
Excesive Worry / Anxiety
Nervous Breakdown
Nephritis
Kidney / Bladder Infection
Freqeuent /Painful Urination

Kidney Stone
Albumen or Blood in Uring
Discharge from Penis
Prostrate Grand Trouble
Gonorrhea or Syphillis
Urethritis
Herpes Virus Infections
Human Immunodefciency Virus Sero+
Menstrual Problem
Irregular Bleeding
Breast Lumps
Excessive Vagina; Discharge
Infected Pelvic Organs
Intestinal Troubles
Colitis
Hernia (Rupture)
Ulcers (Stomach / Duodenum)
Gall Bladder / Gall Stones
Jaundice / Hepatitis
Abdomenal Pain

Rectal Bleeding / Hemorthoids
Swollen or Painful Joints
Gout
Arthritis / Rheumatism
Bursitis
Bone / Joint Disorders
Broken Bones
Shoulder Dislocation
Knee Problems
Neck/Back Problems
Pilonidial Curst
Sinus Infection
Hay Fever
Ear / Nose / Throat problem
Eye Disease
Skin Problem
Surgery (Specify)
Genital Warts

Please indicate any medications or pills you are taking NOW (IMPORTANT):

Do you have any medical or physical problem which restricts your activity? Yes:__ No: __ If yes, please explain throughly:
____

Tobacco: Do you use tobacco in any form (smoking, chewing, snifing)? Please specify: ______________________

Previous Hospitalizations:

Year	**Diagnosis**	**Treatment - Operation**

Are you currectly under a physician care? Yes: __ No: __ If yes, explain: ______________________________
____

The previous statements are all true to the best of my kowledge. Date: __ __ / __ __ / __ __ __ __ Student Sugnature: ______________

PHYSCIAL EXAMINATION --- OPTIONAL

We strongly recommend a thorough physical examination prior entering the University. The student health service does not routine entrance physical examinations.

Height: ___________

Weight: ___________

Snellen	R	L	Hearing		Blood Pressure
			R	L	
Vision without glasses					
Vision with glasses					

Condition	Nutrition	Skin	Ears	Eyes	Nose	Mouth	Breast	Heart
Normal								
Abnormal								
Condition	Lungs	Ungunal Rings	Genitalia	Personality	Bones & Joints	Pap Smear	Central Nervous	Neck
Normal								
Abnormal								

Comments on abnormal findings: ______________________________________

Physician's Signature: ______________________________ Date: ______________