



THE BAHAMAS BAPTIST
COMMUNITY COLLEGE
P.O. BOX N-4830
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MEDICAL RECORD FORM

Please return completed form in a sealed envelope marked "Medical Information" to the Admissions Office.

Part A: General Information (To be completed by applicant)

- Name: _____
(Mr./Miss/Mrs.) Surname First Middle Maiden
- DOB: _____ Age: _____ National Insurance #: _____
- Local Address: _____
House # Street P.O. BOX
- Home Telephone #: _____ Work Telephone #: _____ Other: _____
- Emergency Contact: _____
Name Relationship Telephone #

PART B: Personal Medical History (To be completed by applicant)

- Has any member of your immediate family ever suffered from any of the following conditions?

| | | | | | | |
|---------------------|---------|--------|---------------------|---------|--------|--------------|
| Tuberculosis | YES () | NO () | Diabetes | YES () | NO () | Other: _____ |
| High Blood Pressure | YES () | NO () | Emotional Disorders | YES () | NO () | _____ |
| Heart Disease | YES () | NO () | Cancer | YES () | NO () | _____ |
- Please list any food/drug allergies you may have: _____
- Please list any medications you are currently taking and the conditions they have been prescribed for: _____

- Do you have or received treatment for any of the following conditions:

| | | | | | | |
|-------------------------|---------|--------|----------------------|---------|--------|--------------|
| Asthma | YES () | NO () | Pneumonia | YES () | NO () | Other: _____ |
| Diabetes | YES () | NO () | Prolonged Depression | YES () | NO () | _____ |
| Heart Disease | YES () | NO () | Rheumatic Fever | YES () | NO () | _____ |
| Severe Menstrual Cramps | YES () | NO () | Ulcers | YES () | NO () | _____ |
| Kidney Disease | YES () | NO () | Urinary Infections | YES () | NO () | _____ |
| Hepatitis | YES () | NO () | Venereal Disease | YES () | NO () | _____ |
| High Blood Pressure | YES () | NO () | | | | |

I certify that all statements given in this application are true and accurate.

Signature of Applicant

Date

Part C: To be completed by your personal physician

1. Please tick if normal; if abnormal please state problem(s) in space provided:

| | | | | | | | |
|---------|---|-----------|---|-------------------|---|-------------|---|
| Eyes | Δ | Heart | Δ | Skin | Δ | Pulse | Δ |
| Ears | Δ | Vascular | Δ | Lymph Nodes | Δ | Respiration | Δ |
| Nose | Δ | Lungs | Δ | Muscular/Skeletal | Δ | B/P | Δ |
| Mouth | Δ | Breasts | Δ | Nutrition | Δ | Height | Δ |
| Throat | Δ | Abdomen | Δ | Neurological | Δ | Weight | Δ |
| Thyroid | Δ | Genitalia | Δ | Spine | Δ | Urine | Δ |
| Chest | Δ | Rectal | Δ | Vision | Δ | | |
| Stool | Δ | Behavior | Δ | Temperature | Δ | | |

Problems: _____

Please Note: All students forty (40) years and under are required to have either two (2) doses of MMR or one (1) dose of MMR plus one (1) dose of measles and one (1) dose of rubella vaccine.

All students must present evidence of a completed D.T. Booster given within the last five (5) years.

2. FBC: _____ Hb: _____ VDRL: _____

3. Assessment: _____

4. Mantoux – Date Given: _____ Results: _____
dd/mm/yy

5. Chest X-ray Results(if Mantoux Poositive): _____ Date: _____
dd/mm/yy dd/mm/yy

6. D.P.T.: Primary series completed _____ Polio: Primary series completed _____
dd/mm/yy dd/mm/yy

7. Last D.T. Booster: _____ Repeat if over 5 years duration: _____
dd/mm/yy dd/mm/yy

8. MMR Vaccine – 1st dose: _____ 2nd Dose: _____
dd/mm/yy dd/mm/yy

9. Measles Vaccine: _____ Rubella Vaccine: _____
dd/mm/yy dd/mm/yy

Physician's Name (Please) Business Telephone # Business Address

Physician's Signature

