BAMSI
Bahamas Agriculture & Marine Science Institute

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Office of Admissions
Telephone: 242-397-6580
Email: admissions@bamsibahamas.edu.bs

MEDICAL & MENTAL EVALUATION FORM

Please Return completed form in a sealed envelope to the Admissions Office

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

1. Name:_____
(Mr./Miss/Mrs.) Surname First Middle Maiden

2. DOB:_____Age: National Insurance#:_____

3. Local Address:_____
House# Street P.O. Box

4. Home Telephone#:_____ Work Telephone#:_____ Other:_____

5. Emergency Contact:_____
Name Relationship Telephone#

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

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

Tuberculosis	YES ( )	NO ( )	Diabetes	YES ( )	NO ( )
High Blood Pressure	YES ( )	NO ( )	Emotional Disorders	YES ( )	NO ( )
Heart Disease	YES ( )	NO ( )	Cancer	YES ( )	NO ( )

Other: _____

2. Please list any food/chug allergies you may have: _____

3. Please list any medications you are currently taking and the conditions they have been prescribed for: _____

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

_____ _____
Signature of Applicant Date

PART C: (To be completed by the Examining Medical Office..)

a) Height_____ Weight_____

b) Visual Acuity
Without Glasses R6/_____ *L.16*
With Glasses R6/_____
L./6_____

c) Hearing: Right Ear_____ Left Ear_____

Lymphatic glands:_____

Pulse:_____

Blood Pressure:_____ Systolic:_____ Diastolic_____

e) Respiratory System_____

X-Ray Chest (only if recommended): _____

f) Abdomen_____
Spleen_____

g) Urine _____ Sugar _____

h) Any observable physical defects in addition to general record of observation

i) Is the student on any treatment?
If any, please specify_____

j) Any other observation of importance

_____

_____

_____

PART D: To be completed by your personal physician

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

Eyes	o	Heart	o	Skin	o
Vascular	o	Lungs	o	Muscular/Skeletal	o
Mouth	o	Breasts	o	Nutrition	o
Abdomen	o	Neurological	o	Thyroid	o
Genitalia	o	Spine	o	Chest	o
Rectal	o	Stool	o	Behavior	o
Temperature	o				

Problems:_____

_____

_____

Please Note: 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 Positive):_____ 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:_____

Part E: Mental Evaluation

What diagnosis has patient received? (Please tick yes or no.)

Anxiety	D	yes	D	no	Depression	D	yes	D	no
Post-traumatic stress disorder	D	yes	D	no	Epilepsy	D	yes	D	no
Somatoform	D	yes	D	no	Psychosis	D	yes	D	no
Suicidal	D	yes	D	no	Greif rejection	D	yes	D	no
Deliberate self-harm	D	yes	D	no	Insomnia	D	yes	D	no
Schizophrenia	D	yes	D	no	Brain disorder	D	yes	D	no
Seizure	D	yes	D	no	Mental retardation	D	yes	D	no
Dementia	D	yes	D	no	Bipolar	D	yes	D	no
Alcohol / substance abuse	D	yes	D	no	Spousal / child abuser	D	yes	D	no
Childhood disorders	D	yes	D	no	Other (specify below)	D	yes	D	no

If you ticked yes for any of the above please state the prescribed non-drug treatments and/or prescribed drug treatments during admittance and/or clinic visits.

_____

_____

_____

_____

Is the student physically and mentally fit for College Education? Yes[ ] No [ ]

Comments:

_____

_____

_____

Physician's Signature

Date

Physician's Stamp