Form:

The University of Fiji

APPENDIX 2

MEDICAL FORM

Student ID number: _____

PERSONAL DETAILS

Student Name:		**Programme:**	
Residential Address:		**Postal Address:**	
Date of Birth:	**Gender:**	**Marital Status:**	**Nationality:**
Telephone:	**Mobile:**	**Fax:**	**Email:**

Names and Address of your Next of Kin	**Relationship**	**Telephone**	**Fax**
Name and Address of your Employer (if any)		**Telephone**	**Fax**
Name and Address of School you last attended		**Telephone**	**Fax**

MEDICAL RECORD

	Yes	**No**
Have you ever suffered from malaria (treatment), diabetes, hypertension, heart conditions, asthma or respiratory illness? If yes, give details _____ _____		
Have you suffered from any serious injuries or illness? If yes, give details _____ _____		
Have you had any surgical operation? If yes, give details _____ _____		
Have you or has any member of your family ever suffered from TB, mental disease, fits or epilepsy or been treated in an institution for any of these diseases? If yes, give details _____ _____		
Do you suffer from an allergy e.g. food, drugs, chemicals, plants, animals or other, etc? If yes, give details _____ _____		

I hereby certify that the information supplied above is correct.

Signature: _____ Date: _____