

Tibetan Scholarship Program (TSP)

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 validated copy of your medical sheet.

REQUIRED IMMUNIZATION <small>Enter the month and year for each dose received</small>	Series		Booster		IMMUNIZATION SCHEDULE <small>(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</small>
	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)					

4. Skin Testing for Tuberculosis (Within 3 months of enrolling). Have your received 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: _____
Physician, Health Agency, or School

Dated: ___ / ___ / _____

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	

<i>Have you ever had or have now? Please circle</i>	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 Excessive Worry / Anxiety Nervous Breakdown Nephritis Kidney / Bladder Infection Frequent /Painful Urination	Kidney Stone Albumen or Blood in Uring Discharge from Penis Prostrate Grand Trouble Gonorrhea or Syphillis Urethritis Herpes Virus Infections Human Immunodeficiency 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 Pilonidal Curst Sinus Infection Hay Fever Ear / Nose / Throat problem Eye Disease Skin Problem Surgery (Specify) Genital Warts
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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 currently under a physician care? Yes: __ No: __ If yes, explain: _____

The previous statements are all true to the best of my knowledge. Date: ___/___/_____ Student Sugnature: _____

PHYSICAL 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: _____