MINISTRY OF EDUCATION

Scholarships and Advanced Training Division

Level 10, Tower A, Education Towers, 5 St. Vincent Street, Port of Spain
Trinidad and Tobago, West Indies
Tel: (868) 622-2181 Ext 537, 538, 539, 544, 552, 558, 579 Web: www.scholarships.gov.tt

CONFIDENTIAL

MEDICAL FORM TO BE COMPLETED PRIOR TO THE EXECUTION OF SCHOLARSHIPS OFFERED BY THE GOVERNMENT OF TRINIDAD AND TOBAGO

All candidates of government scholarships are required to submit a Medical Form. Medical Forms must be presented to the Scholarships and Advanced Training Division prior to the execution of the scholarship agreements.

GUIDELINES FOR COMPLETING THIS MEDICAL FORM

PART A – PATIENT HEALTH QUESTIONNAIRE

All scholars are required to complete Sections 1 to 3 of this form.

PART B-MEDICAL CERTIFICATE OF EXAMINATION

This section is to be completed by a Registered Medical Practitioner and it includes a full medical examination.

Please note that this form must be completed in its entirety by both the Scholar and Medical Practitioner.

PART A – PATIENT HEALTH QUESTIONNAIRE

SECTION 1: SCHOLAR INFORMATION (*Complete using BLOCK letters)*

Name: _____

Address:_____

Date of Birth: ____/____/____ **Age:** _____ **Gender: M** ☐ **F** ☐

Contact Number: _____ **Email:**_____

Name of Parent/Next of kin: _____ **Contact No:** _____

Name of Primary care physician: _____ **Contact No:** _____

Have you been awarded a scholarship previously? Yes ☐ **No** ☐

If yes, please state _____

SECTION 2: GENERAL HEALTH

Do you have any pre-existing medical condition that may interfere with your ability to complete the course of study? ☐ Yes ☐ No

If yes, give details_____

Have you ever had any surgeries, serious acute illnesses, significant injuries or been hospitalized?
☐ Yes ☐ No

If yes, please give details _____

_____

Do you have any physical disabilities? □ Yes □No

If yes, please explain _____

Do you have any learning disabilities? □ Yes □No

If yes, please explain _____

Do you have any chronic medical condition? □ Yes □ No

If yes, please explain _____

Are you currently taking any prescription medications/herbal preparations? □ Yes □No

If yes, please state the medication and the dosage_____

Have you ever had any allergic reaction to food, substances, past immunizations and/or medication? □ Yes □ No

If yes, please state _____

Do you have a history of asthma or other respiratory ailment? □ Yes □No

If yes, give details _____

Have you ever received treatment for any psychiatric, mental health, eating disorder or psychological condition? □ Yes □No

If yes, please state _____

SECTION 3: DECLARATION STATEMENT

I hereby verify that all of the information above is accurate and complete and acknowledge that any failure to provide accurate and complete information on my part may result in the cancellation of the scholarship.

Furthermore, I agree to notify the SATD of any material changes in my medical health that may occur throughout the duration of my scholarship.

_____ _____/_____/_____

Scholar's Signature **Date**

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PART B: MEDICAL CERTIFICATE OF EXAMINATION/REPORT

To be completed by the Medical Officer

TO THE EXAMINING MEDICAL OFFICER: *Please note that this individual is being considered for the grant of a scholarship by the Government of the Republic of Trinidad and Tobago. As such, we would appreciate your thoroughness in completing this form.*

Please complete using ***BLOCK*** *letters*

SECTION 1- GENERAL INFORMATION

Name of Patient: _____ Date of Birth: _____/_____/_____

Gender: □ M □ F Weight (kg): _____

Height (m): _____ BMI: _____

SECTION 2- PATIENT HEALTH INFORMATION

1) Based on a medical examination, is the patient medically fit to pursue his/her course of study? □ Yes □ No
   Please explain
   _____
   _____

2) Is the patient at present (a) undergoing a course of treatment
   (b) receiving medical attention
   (c) requiring medical attention.
   If so, please give details
   _____
   _____

3) Do you recommend any additional treatment to be provided to the patient during his/her course of study? □ Yes □ No
   If yes, please explain
   _____
   _____

4) Do you recommend that the patient be referred for additional medical attention?
   _____
   _____

PHYSICIAN VERIFICATION

I certify to the best of my knowledge that the above mentioned information is true and complete.

Name of Physician: _____

Address: _____

Telephone No._____

Signature: _____

Medical Board Registration Number: _____ Date: _____

Physician's Stamp