



University of Doha For Science & Technology (UDST)  
College of Health Sciences (CHS)

**CONFIDENTIAL Student Medical Assessment Form**

This medical form must be completed by all students accepted into any of the College Health Sciences including Medical Radiography, Respiratory Therapy, Nursing and Midwifery, Paramedicine, Dental Hygiene, Pharmacy Technician, and Environmental Health (when required). Please read the instructions carefully before completing the form.

Students *will not be permitted* to attend clinical/work term courses until this form has been completed and submitted to the practice lead at the College of Health Science.

UDST assumes no financial responsibility for the completion of this form and/or necessary diagnostic tests/reports.

ONCE COMPLETED, KEEP A COPY OF THIS FORM FOR YOUR RECORDS

**To be completed by the student prior to physician assessment:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Student Number: \_\_\_\_\_ Program: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

**Release of Information** (Please sign before your physical examination)

I, \_\_\_\_\_, consent to have this medical information released to the University of Doha for Science & Technology and if required to our Healthcare facility affiliates.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**All sections must *be completed by a physician***

**Section 1: Physical Examination:**

**This section must be completed by a qualified healthcare provider (QCHP registered & licensed)**

Physical Exam abnormal findings	Yes	No	If yes, please specify
ENT (e.g., Hearing impairment)			
Heart (e.g., BP problems)			
Respiratory System			
Abdomen			
Genitourinary System (e.g., Kidney)			
Nervous System			
Endocrine System			
Allergies			
Impaired Vision/color blindness			
Special Needs			

Physician's Name: \_\_\_\_\_



Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Section 2: Communicable Disease/Immunization Record/Screening Report**

*You must provide a copy of all serology reports*

	DATE (year/month/day)	RESULTS
Chest X-Ray		
HIV		
Hepatitis C		
Hepatitis B Screening (HBsAG)		
Hepatitis B antibody (HbsAb) (titer and immunity level)		

Physician's Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

TB Screening and PPD	Date (year/month/day)	Results
Mantoux (two steps are required if status unknown)	First: _____	_____ mm of induration
	Second: _____	_____ mm of induration
Quantiferon (if required)		

Immune Status	Date(year/month/day)	Immune/Non-immune
Rubella		Immune____ Non-Immune_____
Measles		Immune____ Non-Immune_____
Mumps		Immune____ Non-Immune_____
Varicella		Immune____ Non-Immune_____
Tetanus/Diphtheria (Pertussis) [Td/T-dap]		Immune____ Non-Immune_____
Hepatitis B (include all dates)		Immune____ Non-Immune_____

Immunization	DATE (year/month/day)
Td (every 10 years)	
MMR (include all dates)	
Optional/ If required by the facility	
Flu vaccination (if required)	

Physician's Name: \_\_\_\_\_



Signature: \_\_\_\_\_ Date: \_\_\_\_\_