
International Cooperation and Development Fund



MEDICAL REPORT

FOR

**International Higher Education
Scholarship Programs 2009**

PART 1: HEALTH DECLARATION

PART 2: MEDICAL EXAMINATION FORM

Applying for: National Yang-Ming University (NYMU)

Master's Program in International Public Health

INSTRUCTION :

PART 1: Personal Details and Health Declaration — to be completed by the applicant

I hereby certify that the following information is true and complete, and agree that any misrepresentation or deliberate omission of a material fact on this form may result in the withdrawal of an offer of a place or scholarship, or may result in the termination of any such offer at a future date. I hereby grant the TaiwanICDF permission to share information contained in my Medical Examination Form with relevant authorities.

X

Signature

Date

PART 2: Medical Examination — to be completed by certified physician

☆National Yang-Ming University (NYMU) reserves the right to require the applicant to undergo a future medical examination after he/she arrives in the Republic of China (Taiwan).

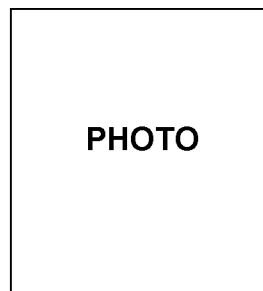
PART 1: HEALTH DECLARATION

Nationality: _____

Name: (Last) _____

(First) _____

(M. Initial) _____



Gender: Male Female **Date of Birth:** _____ Y/ _____ M/ _____ D/

Health History:

Have you ever suffered any of the following conditions? Please mark X in appropriate box

	<i>Yes</i>	<i>No</i>		<i>Yes</i>	<i>No</i>
Psychiatric illness	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis (PTB)	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension (HPT)	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Mellitus (DM)	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Malaria	<input type="checkbox"/>	<input type="checkbox"/>			

Please State (if any)

Other illnesses

.....

Operation / Surgical

.....

Allergic to

.....

Family Medical History (if any)

Father:..... Mother:

Past Year Life: Please select

1. Sleep: 7~8 hours every day Under 7~ 8 hours Often suffer from insomnia
2. If that is basic to exercise each time for 30 minutes and 3 times every week at least, did you achieve?
 No Yes
4. Do you often feel anxious and worried? Few or not Sometimes Often
5. Do you often feel the chest is stuffy? No Sometimes Yes
6. Stomach-ache? No Sometimes Often;. Headache? No Sometimes Often
7. The menarche (girl only): (1) The age of the menarche: _____ years-old
(2) Is menstrual cycle regular? No Yes(Date of partition _____ day)
(3) Do you ever have menstrual cramp phenomenon No Yes

PART 2: MEDICAL EXAMINATION

Physician must complete all questions and give additional comment where necessary. Kindly note that physician is responsible for the information, suggestions and recommendation regarding the applicant's health given in this form.

Certified original lab data need to be attached as reference.

Name of Applicant:

Date of Birth

Y/ M/ D/

Physical Examination:

HEIGHT : _____ cm

WEIGHT : _____ kg

BLOOD PRESSURE : _____ / _____ mmHg

PULSE RATE : _____ /min

VISUAL ACUITY : R _____ L _____

EYES : normal color anomalous other _____

EAR/NOSE/THROAT : normal auditory meatus abnormal cleft lip and palate
impending infarction allergic rhinitis chronic rhinitis other _____

NECK : normal wryneck goiter the lymphoid swelling of gland is big other _____

CHEST : normal thoracic anomaly core noise arrhythmias other _____

CHEST X RAY : normal advertise for like the tuberculosis pleura effusion thoracic abnormality
tuberculosis calcify the spinal column side is curved up cardiac hypertrophy
bronchiectasis other _____

ABDOMEN : normal hepatomegaly splenomegaly hernia other _____

SPINAL COLUMN ARMS AND LEGS : normal scoliosis frog limb articulation deformity
edema other _____

SKIN : normal wart purple plague scabies a dermatitis other _____

MOUTH CAVITY : normal oral hygiene is poor calculus gingivitis milk tooth other _____

Urine Test:

NAD WBC RBC PROTEIN CLUCOSE

Hepatitis B Test:

POSITIVE NEGATIVE

Serological Test for Syphilis:

POSITIVE

NEGATIVE

HIV Test:

POSITIVE

NEGATIVE

THE ORIENTATION INSTITUTION WILL REQUIRE A FURTHER HIV TEST AFTER HE/SHE ARRIVES IN ROC (TAIWAN). THE ONE WITH POSITIVE TEST RESULT WILL BE REJECTED AND SENT BACK HOME IMMEDIATELY.

Pregnancy Test:

POSITIVE

NEGATIVE

Is the applicant now under treatment for any physical or emotional condition?

.....

Do you have any recommendations for the health care of this applicant?

.....

By history and physical examination, is this applicant a carrier of any communicable disease?

.....

CERTIFICATION BY THE MEDICAL OFFICER:

I certify that I have examined the above applicant and in my opinion:

- The applicant is medically fit to undertake a program in Taiwan
- The applicant suffers mental or physical defects and is NOT in good health

Name of physician, Title :.....

Name of Hospital / Clinic :.....

Address :.....

.....

.....

Not valid if without the hospital or clinic's seal