Medical Examination Form for Maritime Applicants

To facilitate the completion of your medical requirements as part of the admission process kindly print out this form (one copy only).

Instruction: Have this form signed by the health personnel who attended to you. This serves as your checklist that all procedures were done. Tampering of this form and the medical test results shall be grounds for non-admission to LPU or cancelation of enrollment. This form shall be submitted to the University Medical and Dental Clinic together with the original medical test results. Submission can be done via courier or in-person.

University Medical and Dental Clinic
Main: (043) 723.0706 local 138
LIMA: (043) 723.0054 local 301
Riverside: (043) 741.5763

Name:____

Home Address: ____

____

Mobile No: ____

Email Add: ____

Marine Transportation ☐ **Marine Engineering** ☐

Semester: ___________ **Academic Year:** _______________

MEDICAL EXAMINATION CHECKLIST

Laboratory and Diagnostic Tests	Signature	Date
1. CBC		
2. Urinalysis		
3. Fecalysis		
4. Chest X-ray		
5. Ishihara Test		
6. Audiometry		
7. Otoscopy		
8. Physical Examination * *A standard PE form can be obtained from the UMDC, should there be none available in your attending Physician's clinic.		

---**To be filled out by UMDC Personnel**---

DATE RECEIVED: ☐

Name of UMDC personnel: ☐

LPU
LYCEUM OF THE PHILIPPINES UNIVERSITY
BATANGAS

FM-LPU-UMDC-25/01

University Medical and Dental Clinic
Main: (043) 723.0706 loc. 138
LIMA: (043) 723.0054 loc.301
Riverside: (043) 741.5763 loc.105

PHYSICAL EXAMINATION REPORT FOR MARITIME STUDENT

COURSE/YR/SECTION: ________________________
Student Number: ______________________________

Purpose: **Admission/ Enrolment**

Last Name		**Given Name**		**Middle Name**
Age:	**Date of Birth** *DAY /MONTH/ YEAR*	**Place of Birth**		**Nationality**
Gender: Male ☐ Female ☐		**Civil Status:** Single ☐ Married ☐		**Religion**
Address:			**Contact Number:**	

I. MEDICAL HISTORY- Has applicant suffered from, been diagnosed, sought advice or treatment from a medical doctor on the following conditions: ***Place a check mark (✓) in appropriate box☐.***

Head or Neck Injury	Yes ☐ No ☐	Other Lung Disorders	Yes ☐ No ☐	Gynecological Disorders *(for women)*	Yes ☐ No ☐
Frequent Headaches	Yes ☐ No ☐	High Blood Pressure	Yes ☐ No ☐	Last Menstrual Period Specify Date :	
Frequent Dizziness	Yes ☐ No ☐	Heart Disease/ Vascular/ Chest Pain	Yes ☐ No ☐	Kidney or Bladder Disorder	Yes ☐ No ☐
Fainting Spells, Fits, Seizures	Yes ☐ No ☐	Rheumatic Fever	Yes ☐ No ☐	Back Injury/Joint Pain/Arthritis	Yes ☐ No ☐
Insomnia or sleep disorders or Other Neurological Disorders	Yes ☐ No ☐	Diabetes Mellitus	Yes ☐ No ☐	Genetic, Hereditary or Familial Disorders	Yes ☐ No ☐
Depression, Other Mental Disorders	Yes ☐ No ☐	Other Endocrine Disorders (e.g., Goiter)	Yes ☐ No ☐	Sexually Transmitted Diseases	Yes ☐ No ☐
Eye Problems/ Refraction	Yes ☐ No ☐	Cancer or Tumor	Yes ☐ No ☐	Tropical Diseases (e.g. Malaria, Typhoid Fever- Specify Date)	Yes ☐ No ☐
Deafness, Other Ear Disorders	Yes ☐ No ☐	Blood Disorders	Yes ☐ No ☐	Schistosomiasis	Yes ☐ No ☐
Nose or Throat Disorders	Yes ☐ No ☐	Stomach Pain, Gastritis or Ulcer	Yes ☐ No ☐	Asthma	Yes ☐ No ☐
Tuberculosis	Yes ☐ No ☐	Other Abdominal Disorders	Yes ☐ No ☐	Allergies (Specify)	Yes ☐ No ☐
				Operation(s) (Specify)	Yes ☐ No ☐

II. MEDICAL EXAMINATION *(To be filled up by examining physician.)*
Enter the data called for. ***Place a check mark (✓)in the appropriate box ☐***

HEIGHT (cm)	**WEIGHT** (kg):	**BLOOD PRESSURE**: Systolic:__________(mm Hg) Diastolic: (mm Hg)		**PULSE RATE**:____/min RHYTHM: ______	**RESPIRATION:______**/min	**BMI**:
VISUAL ACUITY	**FAR VISION**	**NEAR VISION**		**CLARITY OF SPEECH**		
Uncorrected	OD 20/ IOS 20/	ODJ	OSJ	☐ Adequate		
Corrected	OD 20/ IOS 20/	ODJ	IOSJ	☐ Defective		

Alongside columns A, B, C, put a check mark (✓) under 'YES' if Normal. If not Normal, specify findings.

A	YES	Significant Findings	B	YES	Significant Findings	C	YES	Significant Findings
Skin	☐		Neck, Lymph Nodes, Thyroid	☐		Genito-urinary system	☐	
Head, Neck, Scalp	☐		Chest-Breast-Axilla	☐		Inguinal, Genitals	☐	
Eyes, external	☐		Lungs	☐		Extremities	☐	
Pupils, Ophthalmoscopic	☐		Heart	☐		Reflexes	☐	
Ears	☐		Abdomen	☐		Dental (Teeth/Gums)	☐	
Nose, Sinuses	☐		Back	☐				
Mouth, Throat	☐		Anus-rectum	☐				

III. ASSESSMENT
Recommendations:

☐ **Physically Fit**
☐ **Physically Not Fit**

____
Examining Physician
PRC Lic. No.: __________
Date Examined: _________

I hereby certify that I am the same person being examined, whose above information appears in this record and truthfully answered the question asked regarding my health status. I hereby authorize and permit this clinic/hospital and the undersigned examining physician to furnish such information the company needs pertaining to my health status and other pertinent medical findings and do hereby release them from any all-legal responsibility by doing so. I also certify that the medical history contained above, is true and any false statement will disqualify me from admission to maritime program. I have marked/answered all that apply from the list above.

____
Signature over Printed Name
Date:

please see back page →

V. Data Privacy Consent

I hereby declare that by signing:

1. I attest that the information I have written is true and correct to the best of my personal knowledge and I fully understand the above results of my medical examination as explained to me by the University Physician/Nurse.

2. I signify my consent to the collection, use, recording, storing, organizing, consolidation, updating, processing, access to transfer, disclosure or data sharing of my personal and sensitive personal information that I provided to LPU-B including its sister schools/ universities, industry partners, affiliates, external providers, local and foreign authorities regardless of their location and/or registration for the purposes for which it was collected and such other lawful purposes I consent to or as required or permitted by law;

3. I understand that upon my written request and subject to designated office hours of the LPU-B, I will be provided with the reasonable access to my personal information provided to LPU-B to verify the accuracy and completeness of my information and request for its amendment, if deemed appropriate, and;

4. I am fully aware that the consent or permission I am giving in favor of LPU-B shall be effective immediately upon signing of this form and shall continue unless I revoke the same in writing. Sixty working days upon receipt of the written revocation, LPU-B shall cease from performing the acts mentioned under paragraph 2 herein concerning my personal and sensitive personal information.

5. For any data privacy concerns and inquiries, you may contact us through: The Data Protection Officer Lyceum of the Philippines University Capitol Site, Batangas City, Tel No: (043) 723-0706 loc 165; Email: privacy@lpubatangas.edu.ph

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Signature over printed name

Date: ______________