

CERTIFICATE OF PHYSICAL FITNESS

(To be filled by a Registered Medical practitioner in the applicant's country of domicile)

Name of Applicant: TRAN THI MY LINH
Sex M/F: Female
Marital Status: Married
Age: 30 Blood Group: B
Nationality: Vietnamese
Address 563 Ton Dan, Hoa Thot ward, Cam Le district
(City) Danang
(Country) Vietnam
Telephone No. 0905 948 558
Email Address wongmylinh310@gmail.com

I. Medical History (Please give details of any past medical condition which may adversely impact the patient's health at the current time or in the near future).

IA. History of Any Known Illness / Surgery:-

Raised BP –	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	If, yes – on Regular treatment -	Yes <input type="checkbox"/>	No <input type="checkbox"/>
DM –	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	If, yes – on Regular treatment -	Yes <input type="checkbox"/>	No <input type="checkbox"/>
IHD –	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	If, yes – on Regular treatment -	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Stroke –	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	If, yes – on Regular treatment -	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Kidney Disease:	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	If, yes – on Regular treatment -	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Chronic Renal Failure	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	If, yes – on Regular treatment -	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Any history of Surgery/prolonged hospitalization (more than 2 weeks)

Yes ☐/No ☐ ;if yes, details of illness / injury / surgery with duration of illness/treatment

Any history of loss of appetite -	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Any history of loss of Weight -	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Any history of digestive diseases -	Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>
Family History of:	DM <input type="checkbox"/>	HT <input type="checkbox"/> Obesity <input type="checkbox"/>

Any known Allergy:- If so, is the patient on any medication / precautions? NO

II. Physical Examination Medical condition of:-

Height 150 cm Weight 46 Kg Chest NORMAL
Head NORMAL Nose NORMAL Lungs NORMAL
Eyes NORMAL Pharynx NORMAL Heart NORMAL
Ears NORMAL Neck NORMAL Reflexes NORMAL

Remarks if any:-

III. Medical Examination:- Routine Blood, (including Fasting & P.P), Urine Test and Chest X-Ray and any other test as deemed fit by the Medical Practitioner (to rule out any chronic disease).

IV. Summary

1. I believe this applicant IS / ~~IS NOT~~ physically able to carry on a full course of study, involving long hours of work, in a college or university in India.
2. In my opinion the applicant's health and physical condition in general are:

Excellent

Good

Poor

3. I certify that the applicant is up-to-date on routine vaccinations including, among others, MMR, DPT, Varicella, Hepatitis A & B etc.
4. ~~He~~ / She has no physical condition / ailment which would hinder him from pursuing a full course of study in India.
_____ (-)
5. ~~He~~ / She present no evidence of any communicable disease or of any chronic fatigue.
_____ (-)
6. ~~He~~ / She does not have any chronic medical condition which requires regular and sustained medical treatment.
_____ (-)

NOTE: If answers to 4, 5 and 6 above are positive, please give details in Remarks column below.

REMARKS

Date Jan 23, 2019

Signature _____

Address _____



PHÓ GIÁM ĐỐC

BSC KII. Nguyễn Thành Trung
DANANG HOSPITAL

124 Hai Phong St, DaNang City, VietNam

IMPORTANT:

As a protective measure, those planning to study in India are strongly advised to get vaccinated against typhoid / cholera before coming to India.