Tibetan Scholarship Program (TSP)
241 E 32nd Street
New York, NY - 10016

Tibetan Scholarship Program: Medical Certificate

Name: ______________________________ Age: __ __ Sex: M / F
Date of Birth: __ __ / __ __ / __ __ __ __ Tel. #: ____________________ E-mail: ____________________

In Case of Emergency, Please notify

Name: ______________________________ Relationship: ______________
Address: ______________________________
____

Tel. #: ____________________ E-mail address: ____________________

Immunizations required before completion of Registration

Most American Universities require proof of immunization against MMR for all students. This immunization can be shown by the validated record of a physician or clinic. Please have physician validate this form or attached calidated copy of your medical sheet.

REQUIRED IMMUNIZATION Enter the month and year for each dose received	Series		Booster		IMMUNIZATION SCHEDULE
	Month	Year	Month	Year	(A) One dose of live measles vaccine given after the first birthday and Dec. 1967 or a history of the disease diagnosed by a physician. (B) One dose of live rebella vaccine given after the first birthday and Dec. 1967. (C) Series of 4 doses of DTP or DT: with one booster dose every 10 years. NOTE: MMR vaccine (Measles, Mumps and Rubella is the equivalent for Nos 1,2 and 5. Enter date given
1. Measles (7 day, Hard, Rubella)					
2. Rubella (3-day, German Measles)					
3. Diphtheria-Tetanus-Pertussis (DPT) - or Diphtheria-Tetanus - (DT) or (TD)					

4. Skin Testing for Tuberculosis (Within 3 months of enrolling). Have your recevied BCG? Yes : ___ No: ____
Please indicate which test and results PPD __, Chest X-Ray ___, or PPD Or Chest X-Ray: Date Given _______ Result: _____

	Series		Booster		
	Month	Year	Month	Year	
5. Polio (Oral, Trivalent TOPV)					
6. Mumps					

To the best my knowledge, this person has received all the above immunizations. (Past immunizations may be validated from acceptable documents)

Signed: ______________________________ Dated: __ __ / __ __ / __ __ __ __
Physician, Health Agency, or School

Do you have a handicap: Yes:__ No:__ Type of handicap______________________ Attended Needed? Yes: __ No: __
Please indicate any allergies you have to foods, drugs, cosmetics, pollen, etc. ______________________
Explain nature of reaction (Hives, nausea, seizures, etc.) ______________________

Family History: Please indicate the disorders and family relationship:

Disorder	Relationship and age of onset	Disorder	Relationship and age of onset
Diabetes		Cancer	
Migrane Headches		Heart Attack / Stroke Under Age 60	
Blood Disease		Ulcers, Bowel or Intestinal Problem	
High Blood Pressure		Alcoholism	

Have you ever had or have now? Please circle			
	Malaira	Kidney Stone	Rectal Bleeding / Hemorthoids
	Measlesm (Germna per 3 day)	Albumen or Blood in Uring	Swollen or Painful Joints
	Measles (7- day or Hard)	Discharge from Penis	Gout
	Mumps	Prostrate Grand Trouble	Arthritis / Rheumatism
High Blod Pressure	Whooping Cough	Gonorrhea or Syphillis	Bursitis
Heart Trouble	Scarlet Fever	Urethritis	Bone / Joint Disorders
Elevated Cholestrol or Blood Lipids	Chicken Pox	Herpes Virus Infections	Broken Bones
Rheumatic Fever	Infectious Mononucleosis	Human Immunodefciency Virus Sero+	Shoulder Dislocation
Lung Disorders	Cerebgral (Brain) Concussion	Menstrual Problem	Knee Problems
Asthma	Frequent or Severe Headches	Irregular Bleeding	Neck/Back Problems
Pneumonia	Dizziness / Fainting Spells	Breast Lumps	Pilonidial Curst
Chronic Cough: Bronchitis	Severe Head Injury	Excessive Vagina; Discharge	Sinus Infection
Tuberculosis	Paralysis	Infected Pelvic Organs	Hay Fever
Positive TB Test	Epilepsy	Intestinal Troubles	Ear / Nose / Throat problem
Anemia	Depression of Serious Nature	Colitis	Eye Disease
Hemophillia	Excesive Worry / Anxiety	Hernia (Rupture)	Skin Problem
Sickle -Cell Disease	Nervous Breakdown	Ulcers (Stomach / Duodenum)	Surgery (Specify)
Other Blood Disroder	Nephritis	Gall Bladder / Gall Stones	Genital Warts
Diabetes	Kidney / Bladder Infection	Jaundice / Hepatitis	
	Frequeent /Painful Urination	Abdomenal Pain	

Please indicate any medications or pills you are taking NOW (IMPORTANT):

Do you have any medical or physical problem which restricts your activity? Yes:__ No: __ If yes, please explain throughly:

____

Tobacco: Do you use tobacco in any form (smoking, chewing, snifing)? Please specify: ______________________

Previous Hospitalizations:

Year	Diagnosis	Treatment - Operation

Are you currectly under a physician care? Yes: __ No: __ If yes, explain: ______________________

____

The previous statements are all true to the best of my kowledge. Date: __ __/__ __/__ __ __ __ Student Sugnature: ______________________

PHYSCIAL EXAMINATION --- OPTIONAL

We strongly recommend a thorough physical examination prior entering the University. The student health service does not routine entrance physical examinations.

Height: __________

Weight: __________

Snellen	R	L	Hearing R	Hearing L	Blood Pressure
Vision without glasses					
Vision with glasses					

Condition	Nutrition	Skin	Ears	Eyes	Nose	Mouth	Breast	Heart
Normal								
Abnormal								
Condition	Lungs	Ungunal Rings	Genitalia	Personality	Bones & Joints	Pap Smear	Central Nervous	Neck
Normal								
Abnormal								

Comments on abnormal findings: ____

Physician's Signature: ______________________ Date: ______________