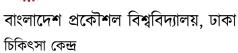


Signature of Student





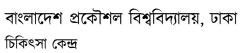
PABX: 9665625 Ext. 7798, 6666 (emergency) Email address: cmo@medical.buet.ac.bd

MEDICAL SCREENING FORM FOR ADMISSION

		Pa	rt I: Pers	onal Informatio	n: to be filled up	by the stu	udent					
Admission Test Roll No	ı.					Merit Posi	ition					
Full Name						Gender		□ м	ale	П	Female	
Father's Name						Age			aio		Tomaio	
Personal Identification Mark (if any)												
		·										
Mobile Phone No.							Email Address					
In case of emergency, person to contact							Relationship					
Emergency Contact No.						Email Add	dress					
Are you currently ur No ☐ Yes If "Yes", please provide												
	der treatme	ent or have	been trea	ated by a psychiatr	ist, clinical psycholog	jist, or other	r mental	health pro	ofessional?			
□ No □Yes If "Yes", please provide	details (dia	gnosis, tre	atment, da	ate and duration et		parate shee						
No ☐Yes If "Yes", please provide 3. Have you been affe	details (dia	gnosis, tre	atment, da	ate and duration et	c. –Please use a sep	oarate shee	t/ attach	ment if ne	cessary).			
No ☐Yes If "Yes", please provide 3. Have you been affe ☐ No ☐Yes	details (dia	ignosis, tre	atment, da	ate and duration et 4. Have you bee No ☐ Ye Name of the Vac	en Vaccinated for CC s (If "Yes" then pro	overate shee	t/ attach	ment if ne	cessary).			
No ☐Yes If "Yes", please provide 3. Have you been affe ☐ No ☐Yes If "Yes" then provide the	details (dia	ignosis, tre	atment, da	ate and duration et 4. Have you bee	en Vaccinated for CC s (If "Yes" then pro	overate shee	t/ attach	ment if ne	cessary).	ficate i	f availab	
No ☐Yes If "Yes", please provide 3. Have you been affe ☐ No ☐Yes If "Yes" then provide the Date:	details (dia	ignosis, tre	atment, da	ate and duration et 4. Have you bee No ☐ Ye Name of the Vac	en Vaccinated for CC s (If "Yes" then pro	overate shee	t/ attach	ment if ne	cessary).	ficate i	f availab	
No ☐Yes If "Yes", please provide B. Have you been affe ☐ No ☐Yes If "Yes" then provide the Date: ersonal Medical Histor	details (dia	ovidential of the english of the eng	atment, da	4. Have you been Name of the Vac	en Vaccinated for CC es (If "Yes" then pro	oviD-19? vide the foll	t/ attach	formation d (please	cessary).) attach certi	and d	uration.	
No ☐Yes If "Yes", please provide B. Have you been affe ☐ No ☐Yes If "Yes" then provide the Date: ersonal Medical Histor	details (dia	ovid of the overland	atment, da	4. Have you bee No Ye Name of the Vac	en Vaccinated for CC es (If "Yes" then pro	oviD-19? vide the foll	t/ attach	formation	cessary).		uration.	
No ☐Yes If "Yes", please provide 3. Have you been affe ☐ No ☐Yes If "Yes" then provide the Date: Personal Medical Histor lave you suffered from contacts	details (dia	ovidential of the english of the eng	atment, da	4. Have you been Name of the Vac	en Vaccinated for CC es (If "Yes" then pro	OVID-19? vide the foll Dose 02 C	t/ attach	formation d (please	e condition	and d	uration.	
No Yes If "Yes", please provide 3. Have you been affe No Yes If "Yes" then provide the Date: Personal Medical Historiave you suffered from contact of the Allergies Acute/ Chronic	details (dia	ovidential of the english of the eng	atment, da	4. Have you been Name of the Vac	en Vaccinated for CC es (If "Yes" then procine mpleted "No", "Yes" or "Not ke Injuries or Defo	Dose 02 C	t/ attach	formation d (please	e condition	and d	uration.	
No Yes If "Yes", please provide 3. Have you been affe No Yes If "Yes" then provide the Date: Personal Medical Historiates are you suffered from the Allergies	details (dia	ovidential of the english of the eng	atment, da	4. Have you been Name of the Vac	en Vaccinated for CC es (If "Yes" then procine mpleted	Dose 02 C	t/ attach	formation d (please	e condition	and d	uration.	
If "Yes", please provide 3. Have you been affer No ☐ Yes If "Yes" then provide the Date: Personal Medical Historiave you suffered from Control of Con	details (dia	ovidential of the english of the eng	atment, da	4. Have you been Name of the Vac	en Vaccinated for CC es (If "Yes" then pro cine mpleted "No", "Yes" or "Not k Injuries or Defo Kidney/ Urinary Disorders Muscular/ Joint	Dose 02 C	t/ attach	formation d (please	e condition	and d	uration.	
If "Yes", please provide 3. Have you been affer No Yes If "Yes" then provide the Date: Personal Medical Historian Company of the Have you suffered from Company of the Have you been affered from Company of the Have you been affered from Company of the Have you suffered from Company of the Have yo	details (dia	ovidential of the english of the eng	atment, da	4. Have you been Name of the Vac	en Vaccinated for CC es (If "Yes" then pro cine mpleted "No", "Yes" or "Not k Injuries or Defo Kidney/ Urinary Disorders Muscular/ Joint Disorders	Dose 02 C	t/ attach	formation d (please	e condition	and d	uration.	

Date







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		/Nata	T. b		cal Information	alatina af th	a atudant)			
		(Note:	To be com	npleted by a registered ph	lysician, who is not a re	elative of tr	ie student)			
Student's Full Na	ame									
Height (cm)					Weight (kg)		_			
Blood Pressure		/mmHg			Pulse Rate			per minute		
Visual Acuity	Righ	nt Eye: 6 /					Regular			
	Left	Eye :6/_					Irregular			
Chest Measurem	nent (cm)									
Regular				While Inhaling		While	e Exhaling			
Clinical Observa	ation (in ca	se no abnor	malities are	e detected, please put "N	IAD" (No Abnormalities	Detected)				
Skin Disease					Ear					
Anemia					Nose					
Hernia					Throat					
Hydrocele					Other (if any)					
Please examine th	ne following	systems an	d indicate a	anv abnormalities:			-			
	hichever is	applicable a	nd provide	details if response is Abr	normal.)			-		
Fyee (ether	Normal	Abnorm	al Detail		Muscular/ Skeletal	Normal	Abnormal	Detail		
Eyes (other than myopia)					Muscular/ Skeletal					
Respiratory					Neurological					
Cardiovascular	T	1			Psychiatric		1			
Gastro- Intestinal					Other					
	.: /DI					•				
Laboratory Examin	nation (Pleas	se attach te Blood G					HBsAg			
ABO			Rh (D)							
				(2)	_					
Physicians comme	ents (if appli	cable)								
Physician's Nam	e and Regis	stration No.		Signature and Date:			Stamp and Address			
				PART III:	Conclusion					
То	be complete	ed by Medic	al Officer of	of BUET (Please conclud	e and indicate if the stu	ident is fit f	or studies at BU	ET with a (✓):		
FIT	UNFI	IT	Comments (if applicable)				Signature, Date and Stamp			
			Re-examine eyes after 7 days							
		Ī	_	mine for Hydrocele and/	or Hernia after 1 month					