Rawalpindi Women University

Medical Undertaking Form

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_D/O\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_holding CNIC/ Form-B # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do hereby solemnly confirm that I have read and understood this medical form. I have understood the need for fitness and to the best of my knowledge; this is a true and accurate description of my medical history and current condition. I am responsible for organizing my own vaccination. I understand that I will be liable for any medical costs incurred whilst on my stay as a result of my condition.

Section A :

|  |  |  |
| --- | --- | --- |
| Age:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Height (cm)\_\_\_\_\_\_\_\_\_\_\_\_ | Weight(kg):\_\_\_\_\_\_\_\_\_\_\_\_ |
| Blood Group:\_\_\_\_\_\_\_\_\_\_\_ | Blood Pressure:\_\_\_\_\_\_\_\_\_\_\_ | Pulse:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Eye sight:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Hearing:\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| General physical exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

* Please state whether you have/have not had any of the following conditions:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Questions | No | Yes | If Yes, Please Give Details: |
| 1 | Asthma, Shortness of breath, respiratory or any other lung disease? |  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 2 | Food allergy? |  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 3 | Severe attack of hay fever/allergy? |  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 4 | Psychiatric or mental illness, including depression? |  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 5 | Do you suffer from haemophilia? |  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 6 | Are you vaccinated against Hepatitis B and C ? |  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 7 | Epilepsy, seizures, fainting attacks or convulsions, Or ever had a stroke? |  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 8 | Are you vaccinated for Covid? |  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 9 | Drug or alcohol dependency? |  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 10 | Pregnancy ? |  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 11 | Do you have diabetes ? |  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 12 | Do you have high blood pressure? |  |  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 13 | Any other disease running in your family, please state\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

Participant Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Doctor’s Details:

|  |
| --- |
| Doctor Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Stamp: |