Form No.: SR-07

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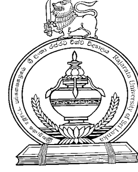
ஸ்ரீ லங்கா ரஜரட பல்கலைக்கழகம்
Rajarata University of Sri Lanka



මිහින්තලේ
மிகிந்தலை
Mihintale

ශ්‍රී ලංකා
ஸ்ரீலங்கா
Sri Lanka

STUDENT REGISTRATION DIVISION

Vice Chancellor: 025-2266644 Registrar: 025-2266511
Telephone (General): 025-2266643, 2266645, 2266646

Asst. Registrar (Registration)
Tel / Fax: 025 – 2266744, Ex: 2141

Director, General Hospital
Medical Officer, District Hospital/ Base Hospital

Dear Sir/ Madam,

<u>Medical Examination for University Enrolment</u>

A complete medical examination with basic investigation is mandatory for all new entrants seeking admission to Rajarata University of Sri Lanka. However, with the very large number of students who are seeking entry, it is an impossible task to complete these medical examinations at the University Medical Centre before they are admitted to the University.

Moreover, once admitted, there is very poor student response for routine medical examinations.

The need for medical examination before admission has been found to be more important since several students with major handicaps have been discovered long after entry to the University.

Therefore, I am compelled to seek your kind assistance in this matter. Every student will be advised to report to the nearest District/ Base/ Provincial Hospital for this medical examination.

Please be so good as to complete the attached form and send it under confidential cover to reach the following address, on or before **10th December 2024.**

Medical Officer
Medical Centre
Rajarata University of Sri Lanka
Mihintale

Thank you for your kind corporation.

Yours faithfully,

Deputy Registrar/Student Registration

Form No.: SR-07

Rajarata University of Sri Lanka

Medical Examination Report

Student's Registration No:…………………………….

This information is strictly for the use of University Health Service, and will not be released to anyone without your knowledge and consent.

Part I of the form should be completed by the student and **Part II** should be completed by a Doctor registered with the Medical Council of Sri Lanka and it should be **signed and stamped.**

Part I (To be filled by the student)

Full Name : ………………………………………………………………………………………
………………………………………………………………………………………
Faculty : ………………………………………………………………………………………
N.I.C. No. : ………………………………………………………………………………………
Age : …………. Sex : Male ☐ Female ☐ Sri Lankan ☐ Foreign ☐
Religion : …………………… Civil Status : Single ☐ Married ☐
Language Competences : Sinhala ☐ Tamil ☐ English ☐
Last School Attended : ………………………………………………………………………………………
Occupation of Father : ………………………………………………………………………………………
Home Address : ………………………………………………………………………………………
………………………………………………………………………………………
………………………………………………………………………………………
District : ………………………………………………………………………………………

Extra-Curricular Activities during the School day:

: Sports Yes ☐ No ☐ If yes indoor games/ outdoor games

Music Yes ☐ No ☐

Dancing Yes ☐ No ☐

Art Yes ☐ No ☐

Religious Work: Yes ☐ No ☐ Leadership Yes ☐ No ☐

Person to notify in case of emergency:

Name : ………………………………………………………………
………………………………………………………………
Address : ………………………………………………………………
………………………………………………………………
………………………………………………………………
Telephone Nos. : Land :……………………….. Mobile:……………………
Relationship : ………………………………………………………………

Family Medical History :

	ALIVE		Dead/ Age at Death	Cause of Death
	Age	State of Health if ill, mention the illness		
Father				
Mother				
Brother/ Sister				
Brother/ Sister				
Brother/ Sister				

Student Medical History: Have you suffered from any of the following:

Infectious diseases :	Mumps	Yes	☐	No	☐
	Measles	Yes	☐	No	☐
	Polio	Yes	☐	No	☐
	Rubella	Yes	☐	No	☐
	Infective Hepatitis	Yes	☐	No	☐
	Whooping Cough	Yes	☐	No	☐
	Chicken Pox	Yes	☐	No	☐
	Tetanus	Yes	☐	No	☐
	Diphtheria	Yes	☐	No	☐
	Sexually transmitted disease	Yes	☐	No	☐

Others (Specify) : …………………..

Worm Infestation :	Filarial	Yes	☐	No	☐
	Others	Yes	☐	No	☐

Tropical Diseases :	Malaria	Yes	☐	No	☐
	Amoebic Dysentery	Yes	☐	No	☐
	Dengue	Yes	☐	No	☐
	Bacillary Dysentery	Yes	☐	No	☐

Others (Specify) : …………………..

Respiratory System :	Frequent Colds	Yes	☐	No	☐
	Hay Fever	Yes	☐	No	☐
	Asthma	Yes	☐	No	☐
	Pneumonia	Yes	☐	No	☐
	T.B.	Yes	☐	No	☐

Others (Specify) : …………………..

Circulatory System :	Heart Disease	Yes	☐	No	☐
	High Blood Pressure	Yes	☐	No	☐

Nervous Breakdown Yes No

Nervous System	: Epilepsy	Yes ☐	No ☐
	Migraine	Yes ☐	No ☐
	Others (Specify) :	…………………..	
ENT	: Ear Infections	Yes ☐	No ☐
EYE	: Short Sight	Yes ☐	No ☐
	Long Sight	Yes ☐	No ☐
Surgical	: Fractures	Yes ☐	No ☐
	Operations	Yes ☐	No ☐
Immunizations	: Have you been vaccinated against Diphtheria, Tetanus, Whooping Cough, Polio, Typhoid, T.B./B.C.G.	Yes ☐	No ☐
Mental Health	: Have you any stress related problem	Yes ☐	No ☐
	Depression	Yes ☐	No ☐
	Exam anxiety	Yes ☐	No ☐
	Suicidal attempt	Yes ☐	No ☐
Menstrual history	: Period :	Regular/ irregular flow slight/ normal/ excessive pain	
Misc	: High Blood Pressure	Yes ☐	No ☐
	Diabetic	Yes ☐	No ☐
	Alcohol/Drugs	Yes ☐	No ☐
	Tobacco/Cigarette	Yes ☐	No ☐
	Allergies (Specify)	…………………..	

Disability : Do you believe that you have a disability that any way requires you to receive special consideration from the University. If so please indicate the type of disability and givea brief description below;
……………………………………………………
……………………………………………………
……………………………………………………
……………………………………………………

I here certify that the information furnished by me is true and accurate.

Date:……………………

………………………………………..
Signature of the Student

Medical Examination Form Part II to be filled by the Medical Officers

Student Registration Number				
Name of Applicant				
Date of Examination				
Height		cm	Weight	kg
Vision		Right eye	Left eye	
Without lenses		6/	6/	
With lens		6/	6/	
Physical Examination				
Pulse per minute	Systolic		Diastolic	
Blood Pressure				
Ears	Right		Left	
Hearing	Right		Left	
Nose				
Throat				
Teeth		Decayed extracted filled Gingivitis	Dentures	
Skin				
Lymph glands				
Thyroid				
Abdomen		Heart		
Hernial orifices		Lung "X" ray		
Genitalia and anus				
Any other defect				
Psychosomatic sings				
Referred to				
Eye Surgeon				
Dental Surgeon				
ENT Surgeon				
General Surgeon				
Orthopedic Surgeon				
Physician				
Chest Physician ("X" ray)				
Psychiatrist				
Skin Specialist				
Gynecologist				
Obstetrician				
	Urine			
	Albumen			
	Sugar			
Other examination				

Date:..............................

....
Initial of Examiner

Official Frank