INTERNATIONAL COOPERATION AND DEVELOPMENT FUND

MEDICAL REPORT
FOR
International Higher Education Scholarship Program 2016

PART 1: HEALTH DECLARATION
PART 2: MEDICAL EXAMINATION FORM

Applying for: ______________________________

INSTRUCTION:

PART 1: Personal Details and Health Declaration — to be completed by the applicant

I hereby certify that the following information is true and complete, and agree that any misrepresentation or deliberate omission of a material fact on this form may result in the withdrawal of an offer of a place or scholarship, or may result in the termination of any such offer at a future date. I hereby grant the TaiwanICDF permission to share information contained in my Medical Examination Form with relevant authorities.

X ________________________________

Signature                                      Date

PART 2: Medical Examination — to be completed by certified physician

☆ The university reserves the right to require the applicant to undergo a future medical examination after he/she arrives in the Republic of China (Taiwan).
PART 1: HEALTH DECLARATION

Nationality: ________________________________

Name: (Last) ________________________________  
(First) ________________________________  
(M. Initial) ________________________________

Gender: Male ☐ Female ☐  Date of Birth: __/__/____

Health History:  
Have you ever suffered any of the following conditions? Please mark X in appropriate box

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric illness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migraine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis (PTB)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hypertension (HPT)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes Mellitus (DM)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart Diseases</td>
<td></td>
<td></td>
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<tr>
<td>Malaria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thyroid Diseases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Diseases</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td></td>
<td></td>
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<tr>
<td>Venereal Diseases</td>
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<td></td>
</tr>
<tr>
<td>Leukemia</td>
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<tr>
<td>Hemophilia</td>
<td></td>
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<tr>
<td>Hepatitis</td>
<td></td>
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<tr>
<td>Measles</td>
<td></td>
<td></td>
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<tr>
<td>German Measles (rubella)</td>
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</tbody>
</table>

Please State (if any)  
Other illnesses
........................................................................................................................................................................

Operation / Surgical
........................................................................................................................................................................

Allergic to
........................................................................................................................................................................

Family Medical History (if any)
Father: .................................................................  Mother: .................................................................

Past Year Life: Please select
1. Sleep: ☐ 7–8 hours every day  ☐ Under 7–8 hours  ☐ Often suffer from insomnia
2. If that is basic to exercise each time for 30 minutes and 3 times every week at least, did you achieve?  
☐ No  ☐ Yes
4. Do you often feel anxious and worried?  ☐ Few or not  ☐ Sometimes  ☐ Often
5. Do you often feel the chest is stuffy?  ☐ No  ☐ Sometimes  ☐ Yes
7. The menarche (girl only): (1) The age of the menarche: ________ years-old  
(2) Is menstrual cycle regular?  ☐ No  ☐ Yes(Date of partition ________ day)  
(3) Do you ever have menstrual cramp phenomenon  ☐ No  ☐ Yes
**PART 2: MEDICAL EXAMINATION**

Physician must complete all questions and give additional comment where necessary. Kindly note that physician is responsible for the information, suggestions and recommendation regarding the applicant’s health given in this form.

Certified original lab data need to be attached as reference.

<table>
<thead>
<tr>
<th>Name of Applicant:</th>
<th>Date of Birth:</th>
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<tbody>
<tr>
<td></td>
<td>Y/ M/ D/</td>
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</tbody>
</table>

**Physical Examination:**

<table>
<thead>
<tr>
<th>Height: cm</th>
<th>Weight: kg</th>
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<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Blood Pressure: mmHg</th>
<th>Pulse Rate: / min</th>
</tr>
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<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

**Visual Acuity:**

- R
- L

**Eyes:**

- ☐ normal
- ☐ color anomalous
- ☐ other

**Ear/Nose/Throat:**

- ☐ normal
- ☐ auditory meatus abnormal
- ☐ cleft lip and palate
- ☐ impending infarction
- ☐ allergic rhinitis
- ☐ chronic rhinitis
- ☐ other

**Neck:**

- ☐ normal
- ☐ wryneck
- ☐ goiter
- ☐ the lymphoid swelling of gland is big
- ☐ other

**Chest:**

- ☐ normal
- ☐ thoracic anomaly
- ☐ core noise
- ☐ arrhythmias
- ☐ other

**Chest X Ray:**

- ☐ normal
- ☐ advertise for like the tuberculosis
- ☐ pleura effusion
- ☐ thoracic abnormality
- ☐ tuberculosis calcify
- ☐ the spinal column side is curved up
- ☐ cardiac hypertrophy
- ☐ bronchiectasis
- ☐ other

**Abdomen:**

- ☐ normal
- ☐ hepatomegaly
- ☐ splenomegaly
- ☐ hernia
- ☐ other

**Spinal Column, Arms and Legs:**

- ☐ normal
- ☐ scoliosis
- ☐ frog limb
- ☐ articulation deformity
- ☐ edema
- ☐ other

**Skin:**

- ☐ normal
- ☐ wart
- ☐ purple plague
- ☐ scabies
- ☐ a dermatitis
- ☐ other

**Mouth Cavity:**

- ☐ normal
- ☐ oral hygiene is poor
- ☐ calculus
- ☐ gingivitis
- ☐ milk tooth
- ☐ other

**Urine Test:**

- NAD
- WBC
- RBC
- PROTEIN
- CLUCOSE

**Hepatitis B Test:**

- POSITIVE
- NEGATIVE
Serological Test for Syphilis:

POSITIVE [ ] NEGATIVE [ ]

HIV Test:

POSITIVE [ ] NEGATIVE [ ]

THE ORIENTATION INSTITUTION WILL REQUIRE A FURTHER HIV TEST AFTER HE/SHE ARRIVES IN ROC (TAIWAN). THE ONE WITH POSITIVE TEST RESULT WILL BE REJECTED AND SENT BACK HOME IMMEDIATELY.

Pregnancy Test:

POSITIVE [ ] NEGATIVE [ ]

Is the applicant now under treatment for any physical or emotional condition?

...........................................................................................................................................................................

Do you have any recommendations for the health care of this applicant?

...........................................................................................................................................................................

By history and physical examination, is this applicant a carrier of any communicable disease?

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CERTIFICATION BY THE MEDICAL OFFICER:

I certify that I have examined the above applicant and in my opinion:

☐ The applicant is medically fit to undertake a program in Taiwan

☐ The applicant suffers mental or physical defects and is NOT in good health

Name of physician, Title : .................................................................

Name of Hospital / Clinic : ..............................................................

Address : .......................................................................................

.................................................................................................

.................................................................................................

Not valid if without the hospital or clinic’s seal