بسم الله الرحمن الرحيم

MALDIVES POLICE SERVICE
Male', Republic of Maldives

MEDICAL ASSESMENT FORM
BLUES FOR YOUTH

PERSONAL DETAILS

1. Full name (in BLOCK LETTERS)		2. Present Address:	
3. Permanent Address:			
4. Date of Birth (DD / MM / YYYY)	5. Place of Birth	6. N.I.D / Passport No:	
7. Sex ☐ Male ☐ Female	8. Mobile No:	9. Home No:	

PARENT / GARDIAN DETAILS

Full Name: …… Relationship: ……..

Permanent Address: …… Present Address: ……

National ID Number: …….. Mobile Number: ……

MEDICAL HISTORY

	Yes	No
Any Serious illness or major surgical procedure ……..	☐	☐
Chronic Diseases (e.g.: HTN, DM etc.) ……..	☐	☐
Tuberculosis, Leprosy or Filaria ……	☐	☐
Bronchial Asthma ……	☐	☐
Fits or Epilepsy ……	☐	☐
Allergies (including insect bites/stings, food, medicine & other substances) ……..	☐	☐
Current medications (prescription & over the counter) ……...	☐	☐
Family history of any disease, fit or epilepsy ……	☐	☐
Have you any H/O Kidney Disorder ……	☐	☐
Do you have any Allergic to Food / Dust / Medicine ……...	☐	☐
Have you any Disorder of Blood (Like Thalassemia) ……..	☐	☐
H/O trauma or accident past 6months …… ……..	☐	☐
H/O or Family H/O spiritual or delusional condition ……..	☐	☐
Any other Medical condition…….. ……..	☐	☐

Note: Please elaborate if you answered "YES" to any of the questions listed above.

……

……

I hereby certify that the information provided above by myself, to the Medical Examination is correct in every particular. I am aware that any false declaration may result in conviction. I am also aware that all related to Medical Check-up is to Be borne by myself under every circumstance.

Date: …… Name of Applicant: …….. Signature of Applicant: …….

I hereby consent that the information given by the applicant under my care is true and any false declaration may result in conviction.

Date: …….. Name of Parent: …….. Signature of Parent: …….

DEVELOPMENT HISTORY

	Gross motor	Fine motor	Appearance
Appropriate for Age:			
Delayed for Age:			

CLINICAL EVALUATION

a. Height: cm b. Weight: kg c. Blood Pressure

d .Pulse : e .R /R :

SYSTEMATIC EVALUATION

		Normal	Abnormal	NOTES: (Describe every abnormality in detail, Enter pertinent item number before each moment)
1	CVS			
2	R.S			
3	GIT			
4	CNS			
5	MSS			

CERTIFICATION BY THE MEDICAL OFFICER

I CERTIFY that I have this day examined Mr./Ms.…….……..…… I.D.No ……..……..…

That the results are set forth, and in my opinion:

*(a) subject to any special observations listed above, the above named is in good health and not suffering from any mental or physical defect which cause labiality to /for

……

(a)

*(b) the above named suffers a mental or physical defect as quoted and /or is not good in health

(b)

Reason for disqualifying

Signature of applicant: Doctor's signature:

Name: Stamp

Date: Date

Medical Services Department stamp: