**OFFICE OF THE PRIME MINISTER**
**(Gender and Child Affairs)**
Tel: 1(868) 627-1163 Ext 2118 FAX: 1(868) 625-4564

**CONFIDENTIAL**

# MEDICAL FORM

**(TO BE COMPLETED PRIOR TO THE COMMENCEMENT OF THE CARE GIVERS TRAINING)**

All applicants selected for the Care Givers Training Programme must complete and submit the Medical Form.

## GUIDELINES FOR COMPLETING THIS MEDICAL FORM

**PART A – APPLICANTS HEALTH QUESTIONNAIRE**

All candidates are required to complete Sections 1 to 3 of this form.

**PART B-MEDICAL CERTIFICATE OF EXAMINATION**

This section is to be completed by a Registered Medical Practitioner and it includes a full medical examination.

**Please note that this form must be completed in its entirety by both the Candidate and Medical Practitioner.**

## PART A – APPLICATION HEALTH QUESTIONNAIRE

### SECTION 1: CANDIDATE INFORMATION (*Complete using BLOCK letters)*

**Name:** ____________________________________________________________________

**Address:**___________________________________________________________________

**Date of Birth:** ____/____/____ **Age:** ________ **Gender: M** ☐ **F** ☐

**Contact Number:** ______________________ **Email:**________________________

**Name of Parent/Next of kin:** ________________________ **Contact No:** _______________

**Name of Primary care physician:** ____________________ **Contact No:** _______________

### SECTION 2: GENERAL HEALTH

Do you have any pre-existing medical condition that may interfere with your ability to complete the Care Giver Training Programme? ☐ Yes ☐ No

If yes, give details_______________________________________________________

Have you ever had any surgeries, serious acute illnesses, significant injuries or been hospitalized?
☐ Yes ☐ No

If yes, please give details _______________________________________________

__________________________________________________________________

Do you have any physical disabilities? ☐ Yes ☐No

If yes, please explain ______________________________________________________

Do you have any learning disabilities? ☐ Yes ☐No

If yes, please explain ______________________________________________________

Do you have any chronic medical condition? ☐ Yes ☐ No

If yes, please explain ______________________________________________________

Are you currently taking any prescription medications/herbal preparations? ☐ Yes ☐No

If yes, please state the medication and the dosage__________________________________

Have you ever had any allergic reaction to food, substances, past immunizations and/or medication? ☐ Yes ☐ No

If yes, please state ________________________________________________________

Do you have a history of asthma or other respiratory ailment? ☐ Yes ☐No

If yes, give details _________________________________________________________

Have you ever received treatment for any psychiatric, mental health, eating disorder or psychological condition? ☐ Yes ☐No

If yes, please state ________________________________________________________

**SECTION 3: DECLARATION STATEMENT**

I hereby verify that all of the information above is accurate and complete and acknowledge that any failure to provide accurate and complete information on my part may result in the cancellation of the training programme.

Furthermore, I agree to notify the OPM-GCA of any material changes in my medical health that may occur throughout the duration of my training.

______________________________ _____/_____/______

**Applicant Signature** **Date**

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## PART B: MEDICAL CERTIFICATE OF EXAMINATION/REPORT

**To be completed by the Medical Officer**

***TO THE EXAMINING MEDICAL OFFICER:*** *Please note that this individual is being considered for Training as a Care Giver by the Government of the Republic of Trinidad and Tobago and this individual will be required to work with children under the new legislation and National standards for the care and protection of children. As such, we would appreciate your thoroughness in completing this form.*
*Please complete using* ***BLOCK*** *letters*

### SECTION 1- GENERAL INFORMATION

Name of Candidate: ___________________________ Date of Birth: _____/_____/_________

Gender: ☐ M ☐ F Weight (kg): _____________________

Height (m): _____________________ BMI: _________________________

### SECTION 2- CANDIDATE HEALTH INFORMATION

1) Based on a medical examination, is the candidate medically fit to pursue his/her course of Study/Training? ☐ Yes ☐ No
   Please explain
   ______________________________________________________________________
   ______________________________________________________________________

2) Is the candidate at present (a) undergoing a course of treatment
   (b) receiving medical attention
   (c) requiring medical attention.
   If so, please give details
   ______________________________________________________________________
   ______________________________________________________________________

3) Do you recommend any additional treatment to be provided to the candidate during his/her course of study? ☐ Yes ☐ No
   If yes, please explain
   ______________________________________________________________________
   ______________________________________________________________________

4) Do you recommend that the candidate be referred for additional medical attention?
   ______________________________________________________________________
   ______________________________________________________________________

**PHYSICIAN VERIFICATION**

**I certify to the best of my knowledge that the above mentioned information is true and complete.**

Name of Physician: ____________________________________________________

Address: ______________________________________________________________

Telephone No.__________________________________________

Signature: _____________________________________________

Medical Board Registration Number: _________________ Date: ________________