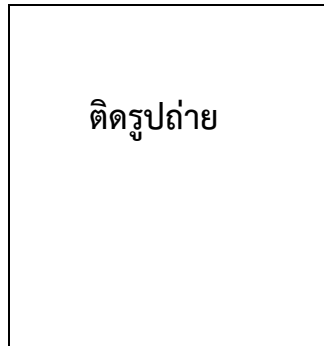


ชื่อทุน

MEDICAL CERTIFICATE



Place of Examination :

Date of Examination :

I Certify that the above I examined

Name : Age Sex ☐ M ☐ F

Date of Birth : Marital Status ☐ M ☐ S

Home Address :

.....

Tel. : E-Mail :

I examined specifically for evidence of any of the following items:

A. MEDICAL HISTORY

Have you ever in your life, including childhood, had any of the following :-

<u>Yes</u>	<u>No</u>		<u>Detailed Information</u>
.....		Asthma	.....
.....		Hypertension	.....
.....		Hemoptysis	.....
.....		Heart Diseases	.....
.....		Diabetes Mellitus	.....
.....		Jaundice	.....
.....		Epilepsy	.....
.....		Edema	.....
.....		Otorrhea	.....
.....		Hernia	.....
.....		Hemorrhoid	.....
.....		Accidents	.....
.....		Fracture	.....
.....		Surgical Operation	.....
.....		Alcohol Consumption	.....

Your L.M.P.

I certify that the above answers are true and complete, I am aware that any falsification or omission of fact result in my immediate discharge from the scholarship program.

.....

(.....) Examinee

B. PHYSICAL EXAMINATION

(to be filled in by physician)

HEIGHT cm
 WEIGHT kg
 BLOOD PRESSURE/..... mmHg
 PULSE RATE per min.

	Normal	Abnormal	Detected Abnormalities
GENERAL APPEARANCE	_____	_____	
SKIN	_____	_____	
SCALP	_____	_____	
LYMPH NODES	_____	_____	
EYES			
<i>VISION -WITH GLASSES</i>			
<i>RIGHT EYE</i>	_____	_____	
<i>LEFT EYE</i>	_____	_____	
<i>COLOR BLINDNESS</i>	_____	_____	
<i>TRACHOMA</i>	_____	_____	
EARS	_____	_____	
<i>OTOSCOPIC EXAM.</i>	_____	_____	
NOSE	_____	_____	
PHARYNX & TONSILS	_____	_____	
TEETH	_____	_____	
THYROID GLAND	_____	_____	
LUNGS	_____	_____	
HEART	_____	_____	
ABDOMEN	_____	_____	
LIVER/SPLEEN	_____	_____	
HERNIA	_____	_____	
EXTERNAL GENITALIA	_____	_____	
<i>ULCER</i>	_____	_____	
ANUS	_____	_____	
SPINE	_____	_____	
LOCOMOTOR/SENSATION	_____	_____	
REFLEXES	_____	_____	
OTHERS	_____	_____	

C. LABORATORY EXAMINATION

1. BLOOD EXAMINATION

BLOOD GROUP
HEMOGLOBIN GM%
HEMATOCRIT %
BLOOD FILM
MARARIA _____ NEGATIVE _____ POSITIVE
MICROFILARIA _____ NEGATIVE _____ POSITIVE
(For Clinical Suspected Case Only)
WBC % CELLS/cu.mm.
PMN %
LYMPH %
MONO %
EOS %
BASO %
OTHERS %

2. SEROLOGICAL TEST

VDRL _____ NEGATIVE _____ POSITIVE

3. URINE/URETHRAL EXAMINATION

URINALYSIS
COLOR
SP. GRAVITY
pH
SUGAR
ALBUMIN
BLOOD
BACTERIA
OTHERS
MICROSCOPIC EXAM.

URINE PREGNANCY TEST

(For Female Only) _____ NEGATIVE _____ POSITIVE

URINE EMIT TEST (Opiate, Amphetamine, Marijuana)

_____ NEGATIVE _____ POSITIVE

URETHRAL DISCHARGE SWAB MICROSCOPIC EXAM.

(For Clinical Suspected Case Only)

FINDINGS

4. BIOCHEMICAL ANALYSIS

CREATININE
FBS
CHOLESTEROL
TRIGLYCERIDE

5. STOOL EXAMINATION

PARASITES

E. HISTOLYTICA _____ NEGATIVE _____ POSITIVE

OTHERS

6. CHEST X-RAY

FINDINGS
.....

7. OTHER EXAMINATION

(SUGGESTED BY CLINICAL EXAM PHYSICIAN)

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

Place of Examination :

Date of Examination :

Examiner's Name :

Examinee's Name :

I hereby certify that the examinee is

_____ physically ready for study abroad.

_____ physically not ready for study abroad.

.....
SIGNATURE OF MEDICAL
COMMITTEE

.....
TITLE

.....
DATE

ชื่อทุน

MENTAL HEALTH EXAMINATION

ติดรูปถ่าย

Place of Examination :

Date of Examination :

I Certify that the above date I examined

Name : Age Sex ☐ M ☐ F

Date of Birth : Marital Status ☐ M ☐ S

Home Address :

.....

Tel. : E-Mail :

Summary of Results :

I hereby certify that the examinee has no current evidence of psychiatric disturbance that interferes with the ability to study.

(Signature)

(.....)

Psychologist

(Date)

(Affiliation)