



**MEDICAL FORM & HEALTH RECORD (3 PAGES)  
VETERINARY TECHNOLOGY PROGRAM (VTEC)  
FACULTY OF SCIENCE & TECHNOLOGY**

**APPLICANT INSTRUCTIONS: Complete ONLY if you are offered a seat in the program**

1. After you have accepted the seat offer, you must fulfill the following requirements:
  - a) Physical examination must have been completed within the last 12 months.
  - b) Vaccinations are highly recommended for your own protection and the protection of those you are in contact with. Prior to entering the program, we anticipate you will have completed the following vaccinations:
    - i) \*Rabies vaccine – preventative series (3 vaccines in 21 days): REQUIRED.  
*\*Clinic for Rabies vaccine will be arranged for VTEC student in mid-September upon submitting the signed "Doctor's Permission to have Rabies Vaccine" form which is attached to the Vaccination Record documentation.*
    - ii) Tetanus and Diphtheria vaccination within the last 10 years: REQUIRED.
    - iii) Hepatitis B vaccination: RECOMMENDED.
    - iv) MMR vaccination: RECOMMENDED.
    - v) Polio vaccination: RECOMMENDED.
2. Please sign the Student Consent portion at the bottom of this page.
3. Please give this **Medical Form** to your physician for completion of the Physical Examination portion on pages 2 & 3 and then have your physician return the completed document to the address below.
4. It is the student's responsibility to return the **Vaccination Record** form to the address indicated below and to ensure that all medical requirements are complete and returned well in advance of registration day. **\* TO AVOID DELAYS IN PROCESSING YOUR APPLICATION, YOUR VACCINATION RECORD MUST BE FULLY COMPLETED AND SIGNED with attached supporting documentation that displays your doctor's signature, office name & address, stamp or clinic name on it, indicating you have indeed received the vaccinations.**

**EXAMINING PHYSICIAN INSTRUCTIONS:** This form **is not** to be returned to the applicant following the examination. The physical examination is a **CONFIDENTIAL DOCUMENT. PLEASE PROVIDE INFORMATION REQUESTED and return all three pages to:**

**Mail to:**                    **DOUGLAS COLLEGE**  
**Attention: VTEC Admissions, Enrolment Services**  
 1250 Pinetree Way  
 Coquitlam, BC Canada V3B 7X3

**STUDENT CONSENT**

I hereby authorize (*give permission to*) the examining physician to provide to Douglas College, Registration Office and the Veterinary Technology Program (VTEC), Faculty of Science & Technology any information and/or opinions regarding my health.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Student Number

**HEALTH RECORD**  
**VETERINARY TECHNOLOGY PROGRAM (VTEC)**  
**FACULTY OF SCIENCE & TECHNOLOGY**

Name of Applicant: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Student Number: \_\_\_\_\_

**PERSONAL HEALTH HISTORY:**

Have you ever had, or do you now have any of the following: (Answer YES or NO. If yes, give year)

Diabetes: _____	Rheumatic Fever: _____
Epilepsy: _____	Stomach Problems: _____
Arthritis: _____	Asthma: _____
Other: _____	

Are you on any medications at this time? If yes, indicate type: \_\_\_\_\_  
(Do not include birth control pills)

**DO YOU SUFFER FROM ANY OF THE FOLLOWING?**

Backache: \_\_\_\_\_ Fatigue: \_\_\_\_\_

Joint trouble: \_\_\_\_\_ Swelling of ankles: \_\_\_\_\_

Eczema: \_\_\_\_\_ Other skin trouble: \_\_\_\_\_

High blood pressure: \_\_\_\_\_ Chest pain: \_\_\_\_\_

Allergies, please specify: \_\_\_\_\_

Have you ever received psychiatric treatment? \_\_\_\_\_

**COMMUNICABLE DISEASE RECORD:**

Have you ever had any of the following? Answer YES or NO.

Measles (Red Measles): \_\_\_\_\_ Chicken Pox: \_\_\_\_\_

Rubella (German Measles): \_\_\_\_\_ Whooping Cough: \_\_\_\_\_

Mumps: \_\_\_\_\_ Small Pox: \_\_\_\_\_

**PHYSICAL EXAMINATION: (To be completed by Examining Physician)**

NAME OF APPLICANT: \_\_\_\_\_

General condition: \_\_\_\_\_

Height: \_\_\_\_\_ cm Weight: \_\_\_\_\_ kg

**REVIEW OF SYSTEMS:**

Musculoskeletal System: Back Abnormalities: \_\_\_\_\_

Joint Abnormalities: \_\_\_\_\_

Central Nervous System: \_\_\_\_\_

Respiratory System: \_\_\_\_\_

Cardiovascular System: Heart: \_\_\_\_\_

Blood Pressure: \_\_\_\_\_ Pulse: \_\_\_\_\_ Hgb: \_\_\_\_\_

Gastrointestinal System: \_\_\_\_\_

Genitourinary System: \_\_\_\_\_ Urinalysis: \_\_\_\_\_

Dermatological System: \_\_\_\_\_

Special Senses: Vision R \_\_\_\_\_ /20, L \_\_\_\_\_ /20 Wears Corrective Lenses? \_\_\_\_\_

Hearing \_\_\_\_\_

**HOW LONG HAVE YOU KNOWN THIS APPLICANT?** \_\_\_\_\_

Comments: Please comment on any irregularities or chronic conditions noted that are likely to interfere with the applicant's ability to function as a Veterinary Technologist.

\_\_\_\_\_  
\_\_\_\_\_

Is this applicant on medications at this time (other than BCP)? If yes, please list.

\_\_\_\_\_

**CURRENT MENTAL HEALTH STATUS:** Please comment on the emotional health of this patient, i.e., emotional instability, anxiety, increased stress response.

\_\_\_\_\_

Given the findings, would the applicant be able to cope with the heavy academic and vocational stresses of an animal nursing program?

\_\_\_\_\_

EXAMINED BY: \_\_\_\_\_ DATE: \_\_\_\_\_

PHYSICIAN'S NAME AND ADDRESS (*printed or stamped*)