

**CONFIDENTIAL MEDICAL EXAMINATION FORM**

All applicants for admission to the University Preparatory Program are required to have the following information completed

**To be completed by the student:**

Full Name: \_\_\_\_\_

Date of Birth (Month/Day/Year): \_\_\_\_\_ Country of Birth: \_\_\_\_\_

National ID Number: \_\_\_\_\_ Passport Number: \_\_\_\_\_ Iqama Number: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ P.O. Box: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Email Address: \_\_\_\_\_

Home Telephone Number: \_\_\_\_\_ Mobile Number: \_\_\_\_\_

**Emergency Contacts:**

**Who should we contact or notify in case of serious illness or accident?**

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Business: \_\_\_\_\_ Residence: \_\_\_\_\_ Mobile: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: Business: \_\_\_\_\_ Residence: \_\_\_\_\_ Mobile: \_\_\_\_\_

**Medical Insurance Information:** (It is recommended that all students obtain health insurance)

Name of company: \_\_\_\_\_ City: \_\_\_\_\_ Country: \_\_\_\_\_

Medical Insurance Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

I am the under signed acknowledge that to the best of my knowledge the above information are accurate and true.

Signature of Student: \_\_\_\_\_ Date: \_\_\_\_\_

***If you have any questions or need any help please contact the UPP Admissions Office***

Admissions Office  
University Preparatory Program UPP  
Diplomatic Quarter  
Building No. 3  
P.O. Box 66262, Riyadh 11576  
Kingdom of Saudi Arabia  
Phone: (+966) 920-000-510  
Fax: (+966) 920-000-530  
Email: [uppadmissions@upp.edu.sa](mailto:uppadmissions@upp.edu.sa)  
Website: [www.UPP.edu.sa](http://www.UPP.edu.sa)

Note: for your own safety, if you are under any medication or suffering from any chronic illness, feel free to contact us.

**To be completed by a licensed physician**

Student's name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

	[Yes] [No]		[Yes] [No]		[Yes] [No]		[Yes] [No]
Appendicitis	[ ] [ ]	Pelvic Disorders	[ ] [ ]	Hernia	[ ] [ ]	Poliomyelitis	[ ] [ ]
Chickenpox	[ ] [ ]	Diabetes	[ ] [ ]	Scarlet Fever	[ ] [ ]	Pleurisy	[ ] [ ]
Tonsillitis	[ ] [ ]	Hay Fever	[ ] [ ]	Skin Disease	[ ] [ ]	Malaria	[ ] [ ]
Typhoid Fever	[ ] [ ]	Pneumonia	[ ] [ ]	Rheumatic Fever	[ ] [ ]	Abdominal Pain	[ ] [ ]
Measles	[ ] [ ]	Epilepsy	[ ] [ ]	Tuberculosis	[ ] [ ]	Defective Vision	[ ] [ ]
Mental Illness	[ ] [ ]	Heart Trouble	[ ] [ ]	Headaches	[ ] [ ]	Mumps	[ ] [ ]
Mononucleosis	[ ] [ ]	Joint Pains	[ ] [ ]	Whooping Cough	[ ] [ ]	Joint Pains	[ ] [ ]
Asthma	[ ] [ ]	German measles	[ ] [ ]	Sinus Infections	[ ] [ ]	Diphtheria	[ ] [ ]
Jaundice	[ ] [ ]	Shortness of Breath	[ ] [ ]	Defective Hearing	[ ] [ ]		
Kidney Troubles	[ ] [ ]	High Blood Pressure	[ ] [ ]	Emotional Problems	[ ] [ ]		

Serious Injuries: \_\_\_\_\_ Date: \_\_\_\_\_

Operations: \_\_\_\_\_ Date: \_\_\_\_\_

**General Health Information:**

Blood Group: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Age: \_\_\_\_\_

Eyes: Right: \_\_\_\_\_ Left: \_\_\_\_\_

Ears: \_\_\_\_\_ Nose: \_\_\_\_\_ Lungs: \_\_\_\_\_ Heart: \_\_\_\_\_

Allergies or any medicines to be avoided? \_\_\_\_\_

Is the student on any maintenance medication? If yes, for what condition \_\_\_\_\_

Classification for physical activities: *Please check one:*

[ ] Unlimited participation      [ ] Limited Participation      [ ] No participation

If limited or no participation indicated, please explain why. \_\_\_\_\_

I the under signed, acknowledge that to the best of my knowledge the above information is accurate and true.

Signature of Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Hospital/Clinic Name: \_\_\_\_\_

Contact Number: \_\_\_\_\_ Official Stamp: \_\_\_\_\_