

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
Alfaisal University
Science Building, Ground floor
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
Website: 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: _____