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**OFFICE OF DEPUTY VICE-CHANCELLOR (ASA)
REGISTRAR ACADEMIC**

STUDENTS ENTRANCE MEDICAL EXAMINATION FORM

IMPORTANT

Students are requested to complete part I of this Form, part II should be completed by the Medical Officer examining the student. The completed form should be delivered together with other forms on reporting day.

PART I

(a) Full Name: _____
(Surname or last Name) (Other Names)

1. University Admission No. _____ Phone No. _____

2. National ID No. /Passport No. _____ Gender _____

3. Date of Birth _____ Place of Birth: _____

4. Full Name of Mother/Father/Guardian _____

Phone No. _____ National ID/Passport No. _____

Address: _____

5. Give names and address of two persons who can be contacted in case of an emergency.

Name _____ Relationship _____

Phone No. _____ National ID/Passport No. _____

Address: _____

PART II

1. Have you ever been admitted into a hospital?



If so, state reason for admission and date

2. Have you had any of the following illnesses? (Delete as necessary)

- | | | |
|---|------------------------------|-----------------------------|
| (a) Tuberculosis or other chest infection | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (b) Fits, Nervous disease or fainting attacks | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (c) Heart Disease or Rheumatic Fever | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (d) Any disease of the Digestive System | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (e) Allegies to food or drugs | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (f) Malaria | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (g) Sexuality Transmitted Disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (h) Poliomyelitis | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If the answer to any of the above is yes, please give details with dates

If there are any other-relevant details of your medical history not covered by the above questions, please give particulars. _____

3. Has any member of your family suffered from:

- | | | |
|--------------------------------|------------------------------|-----------------------------|
| (a) Tuberculosis | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (b) Insanity or mental illness | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (c) Diabetes Mellitus | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (d) Heart Diseases | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| (e) Any other Disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

If Yes, kindly give details _____

4. Have you been immunized against any of the following diseases?

(a) Small pox Yes No

(b) Tetanus Yes No

(c) Poliomyelitis Yes No

(d) Any other Disease Yes No

If Yes, kindly give details _____

Signature of Student _____ Date _____

PART III (To be completed by the Examining Medical Officer)

1. Height _____ Weight _____

2. Visual Acuity

Without glasses

With glasses

R.6

L.6

3. Hearing

Right Ear

Left Ear

4. Condition of:

Teeth

Throat

Ear

Lymphatic glands

Nose

5. Circulatory system:

Pulse Heart

Blood pressure Systolic _____ Diastolic _____

6. Respiratory system



Chest X-Ray (optional depending on Clinical findings)

7. Abdomen; any palpable masses-physiological or Pathological?

Liver _____

Spleen _____

Uterus _____ L.M.P _____

8. Urine: Albumin _____ Sugar _____

(a) Is the student on any treatment? Yes/No

If Yes, kindly give details _____

(b) Any other observation of importance _____

Name of Medical Officer _____

Signature _____ **Date** _____

PART IV

To be completed by University of Eldoret Medical Doctor, after the student has registered with the University.

Special Remarks _____

Is the student fit for University Education Yes/No _____

Date _____

Name of University Medical Officer _____

Signature _____ **Date:** _____

