



### MEDICAL EXAMINATION FORM

(To be completed in confidence and signed by a registered Medical Practitioner)

**PART A. (To be filled in by the applicant in presence of the Doctor)**

Name:.....  
Surname Other names, in full

Admission number:..... Faculty.....

Degree/Diploma.....

Date of birth: ...../...../..... Sex..... Nationality..... ID/PP.No.....

Marital Status..... Religion.....

Name and address of Parent/guardian.....

Telephone (Office).....(House)..... (Mobile)..... (E-mail).....

Residence: Boarding  Day Scholar  (tick appropriately)

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**PART B. (To be completed by the Examining Doctor by asking the questions below)**

- a). Have you been hospitalized for more than three days? Yes  No
- b). Have you been treated for Tuberculosis? Yes  No
- c). Do you suffer from peptic ulcers? Yes  No
- d). Do you suffer from any mental condition? Yes  No
- e). Do you suffer from any allergic condition? Yes  No
- f). Do you suffer from any physical disability? Yes  No
- g). Do you suffer from any psychological condition? Yes  No
- h). Do you suffer from anaemia or blood clotting disorder? Yes  No
- i). Do you suffer from epilepsy? Yes  No
- j). Do you suffer from severe asthma? Yes  No
- k). Do you suffer from any other chronic medical condition? Yes  No
- l). Do you have any special dietary requirements? Yes  No

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Doctor's comments on YES answers for a-j above.

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Height.....cm Weight .....kg Blood pressure.....Pulse.....

Visual Acuity: L.....R.....Chest X-ray (No.....)

- |           |                          |                   |                          |                    |                          |
|-----------|--------------------------|-------------------|--------------------------|--------------------|--------------------------|
| 1. ENT    | <input type="checkbox"/> | 4. Genito-urinary | <input type="checkbox"/> | 7. CNS             | <input type="checkbox"/> |
| 2. Dental | <input type="checkbox"/> | 5. GIJ            | <input type="checkbox"/> | 8. Skin            | <input type="checkbox"/> |
| 3. Liver  | <input type="checkbox"/> | 6. Cardiovascular | <input type="checkbox"/> | 9. Musculoskeletal | <input type="checkbox"/> |

Laboratory findings:

(a) Urinalysis..... (b) VDRL..... (c) Stool.....

NOTE: The laboratory report and Chest X-ray film must be submitted together with the medical form on the reporting date.

**PART C. (To be completed by the examining Doctor)**

I have examined .....and found him/her medically fit/unfit to pursue university education. (delete as appropriate)

Doctor's Name..... Reg. No.....

P.O. Box..... Telephone Number:.....

Signature.....Official Stamp..... Date .....

**PART D. FOR OFFICIAL USE ONLY (To be completed by the University Chief Medical Officer)**

Ref. No.....

Registration No.....

Comments.....

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Signature..... Date..... Official Stamp.....