

**MEDICAL FORM**

Registration No. ....

**IMPORTANT**

1. 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 then be submitted to the Chief Medical Officer/Medical Officer in your respective campus on the registration day.
2. Please note that any medical service that the student may require outside the University's Medical Department is direct responsibility of the Parent/Guardian.

**PART 1**

a. Name of candidate .....  
First
Middle
Last//Surname

Sex ..... Nationality ..... Religion .....  
 Faculty ..... Single/Married .....  
 Name, Address and Telephone No. of Parent/Guardian/Next of Kin

.....  
 .....

Name address and telephone of the family Doctor .....  
 .....

Name of preferred private hospital in case of request of admission .....  
 .....

(a) Have you ever been admitted to hospital? Yes/No. ....  
 If so, state reason for admission and date:

.....  
 .....

(b) Have you had any of the following illness?

Tuberculosis or other chest infection	YES/NO
Fits, nervous disease or fainting attacks	YES/NO
Heart disease or rheumatic fever	YES/NO
Allergies of drugs	YES/NO
Allergies to food stuffs	YES/NO
Diabetes mellitus	YES/NO

Mental illness YES/NO

Asthma

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

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

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Date: ..... Signature: .....

**PART II**

(To be completed by the **examining officer**)

- a) Vision .....
- b) Hearing .....
- c) Circulatory pressure ..... systolic ..... diastolic .....  
Random blood sugar ..... Hb level.....  
Blood group ..... Urine chemistry .....
- d) Chest exam (**to include chest x-ray and report**) .....
- e) Is the student on any treatment? .....  
If so, give details .....

- f) Any other observations of importance .....

Name of examining Doctor (from a Government Hospital or from a registered Medical Officer) .....

Signature ..... Official stamp .....

**NOTE:**

Students with Chronic illnesses to register at the Medical Department.  
Form to be filled at least one week before reporting date

**PART III**

(To be completed by Egerton University Medical Officer)

Special remarks .....

Is the student fit for University education? YES/NO

Date ..... Signature .....

**CHIEF MEDICAL OFFICER**