UZIMA UNIVERSITY COLLEGE

A CONSTITUENT COLLEGE OF THE CATHOLIC UNIVERSITY OF EASTERN AFRICA -CUEA.
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OFFICE OF THE REGISTRAR (ACADEMIC AFFAIRS)

STUDENT ENTRANCE MEDICAL EXAMINATION

Students are required to complete PART I of this form and leave PART II and PART III to be completed by the Medical Officer. The form should be returned to the Registrar, Academic Affairs, Uzima University College, P. O. Box 2502-40100 Kisumu –Kenya.

PART I (***To be filled by the student***)

Surname: _____ OtherNames: _____

Date of Birth: _____ Sex: _____ Marital Status: _____

Nationality: _____

Faculty: _____

Department: _____

Admission No: _____

For Emergencies: Name of Contact person: _____

Address of Contact person: _____

Telephone No: _____

1. Would you say your health is good/fair/poor? _____

2. Have you ever been admitted as an in-patient in hospital? YES/NO. If so, please state reason for admission, name of hospital and date:

_____
_____

3. Are you on any medication(s)? YES/NO. If so, please state drug and dosage:

_____
_____

4. Do you suffer from or have you suffered from any of the following? (Tick where appropriate)
   a. Tuberculosis? …… YES/NO
   b. Schistosomiasis? ……..YES/NO
   c. Any respiratory disease? ……YES/NO
   d. Sickle cell disease? ……..YES/NO
   e. Allergies? …… YES/NO
   f. Diabetes? …… YES/NO

g. Any disease of digestive system? …… YES/NO
h. Any disease of the heart? …… YES/NO
i. Any genitor-urinary system? …… YES/NO
j. Nervous disease? …….. YES/NO

If the answer to the above is yes, please give details with dates:
_____
_____

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

6. Has any member of your family suffered from any of the following? (Tick where appropriate)
   a. Tuberculosis? ..... YES/NO
   b. Hypertension? ..... YES/NO
   c. Diabetes? ..... YES/NO
   d. Mental Illness? ..... YES/NO
   e. Heart Disease? …….. YES/NO

7. Do you react to any drug(s) Yes/No If yes state the drug(s) _____
_____
_____

8. Have you been immunized against any of the following:

Hepatitis B? …… YES/NO (If Yes, state the Date _____)
Tetanus? …….. YES/NO (If Yes, state Date _____)
Yellow fever? ……. YES/NO (If Yes, state Date _____)
Others? …… (If any, state the Date _____)

Signature of Student: _____ Date: _____

PART II (***To be filled by the examining Medical Officer***)

- Height: _____
- Weight: _____
- Visal acuity:
  - Without glasses R.6/_____ L.6/_____
  - With glasses R.6/_____ L.6/_____
- Hearing:
  - Right Ear _____ Left Ear _____
- Conditions of:
  - Teeth _____
  - Ears _____
  - Nose _____
  - Abdomen _____
  - Liver _____
  - Spleen _____
  - Urine _____
  - Stool _____

- Circulatory System:
  - Pulse _____

COMMENTS FROM THE EXAMINING MEDICAL OFFICER:
_____
_____
_____

Examining Doctor _____ _____
(Name) Signature & Rubber Stamp

Date: _____