CUK/ASR/FORM15

THE CO-OPERATIVE UNIVERSITY OF KENYA

STUDENT ENTRANCE MEDICAL EXAMINATION FORM

STUDENT NAME:.....**REG. NO.** .....

IMPORTANT:

It is a requirement by the University that all the students joining the University must complete Part 1 of this form. Thereafter he/she must complete Part II with assistance of a qualified and registered medical doctor. Part III will be filled by the examining doctor who will thereafter print on the form his full name and Medical Practitioners' and Dentists Board Registration Number.

The completed form must be returned to the Registrar (ACDRI) together with the letter of Acceptance, on the day of registration.

PART 1:

Surname:.....Other Names:.....

Gender:.....Date of Birth:.....Place of Birth .....

Nationality:.....Marital Status.....No. of Children.....

Name of Parent/Guardian/Next o: .....

Postal Address: .....

Telephone No. (Parent/Guardian): .....

PART II: (To be completed by the student with the help of a doctor / parent / guardian where necessary)

Have you ever been admitted into hospital? .....

If so, when and for what illness? .....

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Have you ever suffered from any of the following?

Condition/ailment	Yes	No	Condition/ailment	Yes	No
Allergies			Thyroid disease		
Anaemia/unexplained syncope			High blood pressure/stroke		
Asthma/epilepsy/diabetes			Jaundice/Hepatitis		
Mental illness			Peptic Ulcer		
Severe headaches			Bilharzia		
Surgeries/back problems			Chest pain/heart disease		
Thyroid disease			Diabetes mellitus		
Tuberculosis/persistent cough for over two weeks			Kidney disease / bladder problems		

Do you/Does anyone in your family have an existing medical condition? Yes/No.
If yes, please elaborate.....

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Vaccination history:	Yes	No	Vaccination history:	Yes	No
Poliomyelitis			Tetanus		
Hepatitis. A			Hepatitis. B		
Meningitis			BCG		

PART III:

RESPIRATORY SYSTEM:

Clinical findings..... Respiratory rate .....

Percussion..... Auscultation .....

ALIMENTARY SYSTEM:

Teeth..... Tongue..... Abdomen.....

GENITO-URINARY SYSTEM:

Urethra discharge..... L.M.P..... Uterus .....

Urine..... S.G..... Albumin..... Sugar.....

Deposit .....

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COMMENTS BY THE EXAMINING DOCTOR

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Doctor's Name (Printed).....Signature and Stamp.....

Medical Practitioners & Dentists Board Reg. No.....Date .....

PART IV:

COMMENTS BY THE UNIVERSITY MEDICAL OFFICER

Remarks .....

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Does the student require any special medical needs? .....

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NAME.....**SIGNATURE:**.....**DATE** .....

IMPORTANT NOTE:

Any student seeking medical services at the University's Dispensary **MUST** identify himself/herself using a Students' Identification Card. All students are eligible for outpatient services at University's Dispensary. Such services shall be provided only when the students are in session. Those requiring hospitalization or specialized care including dental and optical services will be referred and the cost of hospitalization and such specialized treatment or privately sourced medical services will be borne by the student or parent/guardian. Parents/guardians are encouraged to secure NHIF or any other appropriate medical cover for the children.