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KENYA

email:
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GARISSA UNIVERSITY

OFFICE OF THE REGISTRAR

ACADEMICS & STUDENTS' AFFAIRS

STUDENT'S MEDICAL ENTRANCE EXAMINATION FORM Date_____

Important: The completed form should be forwarded to University Clinic Office.

PART I (To be completed by the Student)

Name (*as per KCSE Cert*) …… **Admission No**……

Date of Birth ……Place of Birth……**Gender**: Male [ ]Female [ ]

Nationality…… County…….. **Mobile No**……..

Faculty…….. Department…… Year of Study……

Marital Status: Single [ ] Married [ ] Other……

Name……..of **Parent [ ]/Guardian [ ]/Next of Kin [ ]**

Mobile No…….. **Address**……..

(a) Have you ever been admitted into a hospital? Yes [ ] No [ ]

(b) If Yes (a) state Date……Reason……..

(c) Have you had any of the following illnesses? (*Tick **✓** as appropriate)*

1. Tuberculosis or other Chest Infection …….. Yes [ ] No [ ]
2. Fits, Nervous Disease or Fainting Attacks ……. Yes [ ] No [ ]
3. Heart Disease or Rheumatic Fever ……. Yes [ ] No [ ]
4. Any Allergies to foods or drugs ……. Yes [ ] No [ ]
5. Malaria…….. Yes [ ] No [ ]
6. Sexually Transmitted Diseases…….. Yes [ ] No [ ]
7. Poliomyelitis …….. Yes [ ] No [ ]

(d) If the answer to any of the **(c)** above is yes, please give details **with dates**

_____

_____

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

_____

(f) Have any members of your family suffered from;

1. Tuberculosis?…….. Yes [ ] No [ ]
2. Insanity or mental illness?…… Yes [ ] No [ ]
3. Diabetes Mellitus?…… Yes [ ] No [ ]

4. Heart Disease?……. Yes [ ] No [ ]

(g) Have you been immunized against any of the following diseases?

(h) 1. Small pox …….. Yes [ ] No [ ]

2. Tetanus……. Yes [ ] No [ ]

3. Poliomyelitis…… Yes [ ] No [ ]

(i) Indicate any special medical condition(s) that you might be having that Garissa University should know about…….. ***(j)*** Signature of Student_____ Date _____

PART II (To be completed by the Examining Medical Officer) ***(a)***

Height_____ Weight _____

(b) Visual Acuity:

Without glasses; R. Eye …… L. Eye …….

With glasses; R. Eye …….. L. Eye ……..

Hearing; Right Ear …….. Left Ear ……..

(c) Condition of:

Teeth Throat

Ears Lymphatic glands

Nose

(d) Circulatory System: Blood Pressure:

Pulse_____Heart_____ Systolic _____Diastolic_____ ***(e)*** Respiratory system, chest X-Ray (optional on clinical finding)

_____

(f) Abdomen; any palpable masses-physiological or pathological?

Liver_____ Spleen _____Uterus _____LMP_____

(g) Urine:

Albumin_____ Sugar_____

(h) Is the student on treatment? _____

(i) Any other observation of importance_____

(j)

Name of Officer _____Signature _____Stamp&Date_____

PART III (To be completed by GaU Medical Officer, after the student has registered with the University)

(k) Special Remarks_____

(l) Is the student fit for University Education? Yes [ ] No [ ] _____

(m)

Name of Medical Officer_____Sign_____Stamp&Date_____