The Management University of Africa | MUA

Sponsored by the Kenya Institute of Management

OFFICE OF THE REGISTAR, ACADEMIC AND STUDENT AFFAIRS

STUDENT MEDICAL EXAMINATION RECORD FORM

A. Demographic Information.

Name: ……..…….

Surname *Other name*

Date of Birth: …….. Gender: ……

Admission Number: ……..

Home Address: ……

Box *code* *city*

County: ……. Country: ……

Phone number: ……. Alternate Phone: ……

Next of Kin:…… Relationship:…….…….

Phone Number: …… Alternate Phone:……..……...

Medical cover (if any): ...……

IMPORTANT:

1. Students are requested to complete part I of this form. Part II should be completed by a recognized Medical Officer examining the student. The completed form should then be submitted to the Registrar (ASA) / Chief Medical Officer /Medical Officer on the registration day.

2. Please note that any medical service that the student may require outside what is provided by the university is a direct responsibility of the student/Parent /Guardian.

PART I.

a) Have you ever been admitted to hospital? Yes/No ……..

If yes, state the reason for admissions and date:

……

……..……

b) Have you had any of the following illness? (Please check Y(Yes) and N(No) for each condition).

	Y	N		Y	N		Y	N
Tuberculosis			Asthma			Insomnia		
Fits/ nervous diseases /fainting attacks			Chest infection / Chest Pain			Head Injury		
Heart disease / rheumatic fever			Bronchitis			Appendectomy		
Allergies (|Food or drugs)			Joint Problems			Back Pain		
Diabetes mellitus			Hemorrhoids			Ear Infections		
Sinusitis			Cancer			Heart Disease		
Paralysis			Meningitis			Chronic cough / colds		
Anaemia			Depression			Malaria		
Eczema			Constipation			Epilepsy		
Arthritis			Pneumonia			Mental Illness		
Nausea /Dizziness								

c) If the answer to any of the above is YES, please give details and dates:

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

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I certify that the information given is true:

Students signature…… Date:……

PART II

Patients Full Name:…… Date of Birth:……

a). General Appearance			**b). Vital signs**			
	Normal	**Abnormal**		**Results**	**Normal**	**Abnormal**
Skin			Blood Pressure			
Eyes						
Ears			Temperature			
Nose						
Respiratory			Pulse			
Lungs			Weight			
Muscular skeletal			Height			
Throat			Urinalysis			

Chest X ray(Mandatory)

Is the student undergoing any treatment?.....

If Yes, give details

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Any other observations of importance

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Name of examining Doctor……..

Signature…… Official Stamp……

Part III. (To be completed by the University Medical Officer)

Special remarks:

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Is the student fit for the University Education? YES……. NO……..

MEDICAL OFFICER

Name……

Date:…… Signature:……