AFRICA INTERNATIONAL UNIVERSITY

STUDENT ENTRANCE MEDICAL EXAMINATION

REGISTRATION NO: ……

IMPORTANT:

It is a UNIVERSITY requirement that all the students joining the UNIVERSITY must complete part I of this form. Thereafter he/she must complete part II with assistance of a qualified and registered Doctor or Clinical Officer) from a Government/Mission Health Facility or from a private Hospital **(Not private clinic nor private health Centre).** Part III will be filled by the examining Doctor or Clinician who will thereafter print on the form his full name and Professional Registration Number

PART I

SURNAME……. OTHER NAMES……. GENDER……

DATE OF BIRTH……PLACE OF BIRTH…….

NATIONALITY……MARITAL STATUS……NO. OF CHILDREN……

NAME OF PARENT/GUARDIAN/NEXT OF KIN…….

POSTAL ADDRESS…….

TELEPHONE NO. (HOME)……..

STUDENT MOBILE NUMBER……

NHIF Membership No (Self, Parent, Guardian) ……

PART II (To be completed by the student with the Doctor's/Clinician's help)

Have you ever been admitted into hospital?

……

If so when and for what illness?

……

Have you ever suffered from any of the following?

……

Allergy	YES/NO	Infection mononucleosis	YES/NO
Anemia	YES/NO	Jaundice/Hepatitis	YES/NO
Asthma	YES/NO	Peptic Ulcer	YES/NO
Orthopedic Problems	YES/NO	Mental illness	YES/NO
Bilharzia	YES/NO	Poliomyelitis	YES/NO
Bladder problem	YES/NO	Severe headaches	YES/NO

Chest infections	YES/NO	Surgery	YES/NO
Epilepsy	YES/NO	Thyroid disease	YES/NO
Diabetes mellitus	YES/NO	Tuberculosis	YES/NO
Eye problem	YES/NO	Speech problem	YES/NO
Heart disease	YES/NO	Hearing problem	YES/NO
High blood pressure	YES/NO	Sexually transmitted disease	YES/NO
Blood transfusion	YES/NO	Menstrual disturbances	YES/NO
HIV infection	YES/NO	Are you an any treatment now	YES/NO
Other frequent diseases/Conditions not mentioned above	YES/NO		

If the answer to any of the above is YES, please give details

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……

Where are you getting treatment, and who's your doctor/Clinician?

……
……

Do you have any other medical insurance cover? (if yes specify the name, number, principal member and details of cover ……
……

FAMILY MEDICAL HISTORY

Has any member of your family suffered from any of the following?

Diabetes mellitus	YES/ NO	Heart disease	YES/ NO
Bronchial asthma	YES/ NO	High blood pressure	YES/ NO
Mental illness	YES/ NO	Sickle cell disease	YES/ NO
Other Chronic/Congenital disease or condition			

AUTHORIZATION STATEMENT

I hereby authorize any Doctor, clinician, health facility, medical provider, any insurance company or any company, institution any other person who has any record or information about me and/or any of my family members to provide AFRICA INTERNATIONAL UNIVERSITY with complete information including copies of their records with reference to my sickness or accident, any treatment, examination, advice, or hospitalization. Any photocopy of this authorization shall be regarded as an original copy.

STUDENTS SIGNATURE…… DATE……

PART III: (To be completed by the Examining Doctor/Clinician)

Height……. Weight……..Any deformity……

Visual Acuity……LE 6……..RE 6……

Hearing……. Nose……Throat……

Cranial Nerves……. Sensation…… Co-ordination……

Lymphatic glands……. Reflexes……

CARDIOVASCULAR SYSTEM

Pulse……/Minute Heart murmurs……..

Peripheral Vessels…….. Blood pressure…….

RESPIRATORY SYSTEM:

Chest……. Respiratory Rate……

Percussion……..Auscultation……..

ALIMENTARY SYSTEM

Teeth……. Tongue……Abdomen……

Liver…… Spleen …… Hernia……

GENITO-URINARY SYSTEM

Bladder……. L.M. P……. Uterus……

Deposit……

LABORATORY TESTS

Urinalysis: PH …….. Glucose……. Protein…….
Stool: Ova……. Cyst…… Trophozoites…… Occult……
Blood……
Hemoglobin: ……gm/dl, PCV/HCT……% WBC Count:……/cmm
Comment: ……

OTHER SYSTEMIC EXAMINATION/FINDINGS

……
……
……

OTHER TESTS RECOMMENDED BY EXAMINING DOCTOR/CLINICIAN, and the Test Results
……
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……

COMMENTS BY THE EXAMINING DOCTOR/CLINICIAN

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Doctor's/Clinician's name (Printed)……

SIGNATURE and STAMP…….

Address: ……

Professional Registration Number……DATE……