MASENO UNIVERSITY

OFFICE OF THE REGISTRAR – ACADEMIC AND STUDENT AFFAIRS

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Private Bag,
MASENO - Kenya

STUDENT ENTRANCE MEDICAL EXAMINATION

ADM. NO: _____

IMPORTANT

Students are requested to complete part 1 of this form. The Medical Officer examining the student should complete part II. The completed form should be forwarded to the **Registrar, Academic Affairs, Maseno University PRIVATE BAG MASENO. 40105.**

PART I

(a) Surname: _____ Other Names _____

Date and Place of Birth_____

Nationality _____

Faculty _____

Single/Married_____

Name, Addresses and Telephone number of Parent/Guardian/Next of Kin

_____
_____
_____
_____

NHIF NO_____

(b) Have you ever been in an in-patient hospital or nursing home? **YES/NO.** If so when and for what complaints?

_____
_____
_____
_____

(c) Have you suffered from or had symptoms of any of the following (Delete as necessary).

i.	Tuberculosis or other chest infection	**YES/NO**
ii.	Fits, Nervous disease or fainting attacks	**YES/NO**
iii.	Heart Disease or Rheumatic fever	**YES/NO**
iv.	Any diseases of the digestive system	**YES/NO**
v.	Any disease of the Genital-Urinary System	**YES/NO**
vi.	Allergies to food or drugs	**YES/NO**
vii.	Malaria	**YES/NO**
viii.	Sexually Transmitted Disease	**YES/NO**
ix.	Poliomyelitis	**YES/NO**
x.	Any physical defect or deformity	**YES/NO**
xi.	Any disease not mentioned above	**YES NO**

If the answer to any of the above is yes, please give details with dates.

(d) Is there any other relevant details of your Medical History not covered by the above questions? **YES/NO** if yes, please give particulars

(e) Has any member of your family suffered from:

(i)	Tuberculosis?	YES/NO
(ii)	Insanity or Mental illness?	YES/NO
(iii.)	Diabetes mellitus?	YES/NO
(iv)	Heart Diseases?	YES/NO

(f) Have you been immunized against the following diseases?

(i)	Smallpox…… YES/NO	Date……
(ii)	Tetanus……YES/NO	Date…….
(iii)	Poliomyelitis……YES/NO	Date……

Signature of student _____ Date_____

PART II (To be filled by examining Medical Officer)

(a) Height _____ Weight _____

(b) **VISUAL ACUITY**

Without glasses R.6/_____ 1.6/_____

With glasses R.6/_____ 1.6/_____

(c) Hearing Right Ear_____Left Ear_____

(d) **Conditions of:**

Teeth_____ Throat_____

Ears _____ Lymphatic Glands_____

Nose _____

(e) CIRCULATORY SYSTEM

Pulse _____

Examining Doctor_____ _____

Signature & Rubber Stamp

Date _____

Submit in quadruplicate (Fill in 4 copies)