

OFFICE OF THE DEPUTY VICE CHANCELLOR (ACADEMIC AND STUDENT AFFAIRS)

Please fill in ALL information required, do not leave any blanks

School enrolled in: _____

Student Admission No _____

STUDENTS ENTRANCE MEDICAL EXAMINATION

IMPORTANT: STUDENTS MUST bring this form duly signed during registration
- All x-ray films that report abnormalities and details for pre-existing medical conditions should be brought to the University Medical Officer during registration period.
- Pre-existing medical conditions include; tuberculosis, Epilepsy, Mental disorders, Hypertension, Diabetes, hemophilia, sickle cell disease, peptic ulcer disease, HIV, Heart diseases, asthma and others. This helps the officer in charge of students' health to help you while undertaking your education in Pwani University.

PART 1: DEMOGRAPHY

SURNAME **OTHER NAMES**

Student's mobile No. _____

Student's Email Address _____

Date of Birth: _____ **Nationality:** _____ **Gender:** _____

County: _____ **Religion:** _____ **Marital Status:** _____

| Status of your parents: Tick where applicable | | | | | | |
|---|-------|------|-------------------------|----------|-----------|---------------|
| | Alive | Dead | Parents living together | Divorced | Separated | Single Parent |
| Father | | | | | | |
| Mother | | | | | | |

If alive:
Father's Name:* _____

Father's Tel. No.:* _____

Mother's Name* _____

Mother's Tel. No.:* _____

Name of Guardian where applicable* _____

Guardian Tel. No.:* _____

Location: _____ Sub Location: _____

Full name of the Assistant Chief:* _____

Assistant Chief Mobile No.:* _____ Full name of Village elder* _____

Mobile No. of the village elder:* _____

Who does the university contact when you have a medical emergency or concern if not your parents or Guardian:

Name:* _____ Telephone No.:* _____

KEY * Very Important Information

PART 2 PAST MEDICAL AND SURGICAL HISTORY

Please circle **YES** if you had the condition or **NO** if you never had the said condition

Have you ever been admitted to hospital? (No) or (Yes), if Yes, when _____

What was the diagnosis _____

Have you ever suffered from any of the health conditions/ diseases below? Tick as may apply

| | | | |
|----|---------------------------------------|-----|----|
| 1 | Tuberculosis | Yes | No |
| 2 | Difficulties in breathing | Yes | No |
| 3 | Low hemoglobin level (HB) | Yes | No |
| 4 | Fainting episodes (epilepsy/ syncope) | Yes | No |
| 5 | Asthma | Yes | No |
| 6 | Arthritis | Yes | No |
| 7 | Diabetes | Yes | No |
| 8 | Peptic Ulcer Disease | Yes | No |
| 9 | Poor eye sight/vision | Yes | No |
| 10 | Allergy to medicine/ food/ Dust | Yes | No |
| 11 | Mental condition/ anxiety/ depression | Yes | No |
| 12 | Any other? Name it | | |

If you answered **YES** to any of the above, please bring a medical report on the same to the Officer in charge of students' Health at Pwani university so that you may further be guided on management of the same while in the University.

Note: The student should be guided by his parent(s) or guardian in filling the above medical information and where need be, by the health care providers Nurse, Clinical officer or Medical officer of Health.

Has any member of your family (including extended families whom you have blood relationships like grandfather, grandmother, sisters and brothers to your parents) suffered from any of the above conditions? Yes/ No, if Yes, which disease/s? _____

Student's Signature: _____

Date: _____

Parent/ Guardian Signature _____

Date: _____

PART 3 TO BE FILLED BY EITHER A CLINICAL OFFICER OR MEDICAL OFFICER OF HEALTH BEFORE STUDENT COMES TO PWANI UNIVERSITY

Please make sure you have done the following tests and attach the results

- (i) Urinalysis
- (ii) Pregnancy test for female students
- (iii) Stool for ova and cysts
- (iv) Full haemogram +ESR

PHYSICAL EXAMINATION

| No. | | | | Remarks |
|-----|----------------|-------------------------------------|----------------------------------|---------|
| 1. | Visual acuity | Without glasses R. 6/ L. 6/ | With glasses R. 6/ L. 6/ | |
| 2. | Hearing | Right ear | Left ear | |
| 3. | Lymph nodes | Enlarged | Not Enlarged | |
| 4. | Blood pressure | | | |
| 5. | Heart beat | | | |
| 6. | Respiration | | | |
| 7. | Temperature | | | |
| 8. | Chest | | | |
| 9. | abdomen | | | |
| 10. | Masses | | | |
| 11. | Spleen | | | |
| 12. | Liver | | | |
| 13. | Hernia | | | |

For Mental Disorders, please attach latest medical report

Name of attending psychiatrist: _____

Telephone No. _____

PART 4: Verification by Officer in charge of Pwani University Students' Health Unit

Is the student fit for University Education? Yes/ No

Any follow up recommended? _____

Name of verifying Officer: _____

Signature: _____ Date: _____