# THE CO-OPERATIVE UNIVERSITY OF KENYA

## STUDENT ENTRANCE MEDICAL EXAMINATION FORM

**STUDENT NAME:** ..... **REG. NO.** .....

**IMPORTANT:**
It is a requirement by the University that all the students joining the University must complete Part 1 of this form. Thereafter he/she must complete Part II with assistance of a qualified and registered medical doctor. Part III will be filled by the examining doctor who will thereafter print on the form his full name and Medical Practitioners' and Dentists Board Registration Number.

The completed form must be returned to the Registrar (Academic Affairs) together with the letter of Acceptance., on or before the date of registration.

**PART 1:**

Surname: ..... Other Names: .....

Gender: ..... Date of Birth: ..... Place of Birth .....

Nationality: ..... Marital Status ..... No. of Children .....

Name of Parent/Guardian/Next o: .....

Postal Address: .....

Telephone No. (Parent/Guardian): .....

**PART II:** (To be completed by the student with the help of a doctor / parent / guardian where necessary)

Have you ever been admitted into hospital? .....

If so, when and for what illness? .....

**Have you ever suffered from any of the following?**

| Condition/ailment | Yes | No | Condition/ailment | Yes | No |
|---|---|---|---|---|---|
| Allergies | | | Thyroid disease | | |
| Anaemia/unexplained syncope | | | High blood pressure/stroke | | |
| Asthma/epilepsy/diabetes | | | Jaundice/Hepatitis | | |
| Mental illness | | | Peptic Ulcer | | |
| Severe headaches | | | Bilharzia | | |
| Surgeries/back problems | | | Chest pain/heart disease | | |
| Thyroid disease | | | Diabetes mellitus | | |
| Tuberculosis/persistent cough for over two weeks | | | Kidney disease / bladder problems | | |

Do you/Does anyone in your family have an existing medical condition? Yes/No.
If yes, please elaborate .....

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| Vaccination history: | Yes | No | Vaccination history: | Yes | No |
|---|---|---|---|---|---|
| Poliomyelitis | | | Tetanus | | |
| Hepatitis. A | | | Hepatitis. B | | |
| Meningitis | | | BCG | | |

**PART III:**

**RESPIRATORY SYSTEM:**

Clinical findings..... Respiratory rate .....

Percussion..... Auscultation .....

**ALIMENTARY SYSTEM:**

Teeth..... Tongue..... Abdomen.....

**GENITO-URINARY SYSTEM:**

Urethra discharge..... L.M.P..... Uterus .....

Urine..... S.G..... Albumin..... Sugar.....

Deposit .....

**COMMENTS BY THE EXAMINING DOCTOR**

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Doctor's Name (Printed) ..... Signature and Stamp .....

Medical Practitioners & Dentists Board Reg. No. ..... Date .....

**PART IV:**

**COMMENTS BY THE UNIVERSITY MEDICAL OFFICER**

Remarks .....

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Does the student require any special medical needs? .....

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**NAME** ..... **SIGNATURE:** ..... **DATE** .....

***IMPORTANT NOTE:***

Any student seeking medical services at the University's Dispensary **MUST** identify himself/herself using a Students' Identification Card. All students are eligible for outpatient services at University's Dispensary. Such services shall be provided only when the students are in session. Those requiring hospitalization or specialized care including dental and optical services will be referred and the cost of hospitalization and such specialized treatment or privately sourced medical services will be borne by the student or parent/guardian. Parents/guardians are encouraged to secure NHIF or any other appropriate medical cover for the children.