



MERU UNIVERSITY OF SCIENCE & TECHNOLOGY

P.O. Box 972-60200 Meru-Kenya
Tel: 020-2092048, 020-2069349, 061-23092, 064-30320 Cell Phone: +254 712524293, +254 789151411
+254 725 330826, +254 752 839270, +254 736 229094, 254 725 330827
Website: www.must.ac.ke Email: info@must.ac.ke Fax: 064-30321

REG. NO.....

STUDENTS MEDICAL EXAMINATION IMPORTANT

Students are requested to complete **Part 1** of this Form **Part II** should be completed by the medical Officer examining the Student. The completed Form should be brought personally and presented to the Medical Registration officers on the day of Registration by the Student. **No medical reports should be brought earlier or sent by post**

PART 1

- a) Surname.....Other Names.....
Date and place of Birth.....Nationality.....
Race.....Religion.....
Faculty / school / Institute.....Marital Status.....
Name, Address and Telephone Number of Parent / Guardian / Next - of – Kin.....
.....
- b) Have you ever been admitted into a Hospital?.....
If so, state reason for admission and date.....
.....
- c) Have you had any of the following illnesses?
 - i) Tuberculosis or other chest infection? Yes/No
 - ii) Fits, nervous disease or fainting attacks? Yes/No
 - iii) Heat disease or Rheumatic fever? Yes / No
 - iv) Any disease of the digestive system? Yes/No
 - v) Any disease of Genital urinary system? Yes / No
 - vi) Allergies to food or drugs? Yes/No
 - vii) Malaria? Yes/No
 - viii) Sexual transmitted disease? Yes / No
 - ix) Poliomyelitis? Yes/No

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

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

- i) Tuberculosis Yes / No
- ii) Insanity of metal illness? Yes / No
- iii) Diabetes Mellitus? Yes / No
- iv) Heart Disease? Yes / No
- d) Have you been immunized against any of the following diseases:

- i) Smallpox? Yes / No.....Date:.....
- ii) Tetanus? Yes / No.....Date:.....
- iii) Poliomyelitis? Yes / No.....Date:.....

PART II

(To be completed by the Examining Medical Officer)

- a) Height.....Weight.....
- b) Visual Acuity:
 - Without Glasses R.6/ L. /6.....
 - With Glasses R.6..... L./6.....
- c) Hearing: Right ear.....left ear.....
- d) Condition of:
 - Teeth:.....
 - Nose.....
 - Throat
- e) Lymphatic glands
 - Circulatory system.....
 - Pulse.....
 - Blood pressure.....
- f) Respiratory system.....
 -
 - X-ray Chest.....

(THE STUDENTS BE GIVENTHE CHEST X-RAY FILM TO BRING TO THE UNIVERSITY MEDICAL OFFICER DURING REGISTRATION)
- g) Abdomen
 - Spleen.....
 - Any evidence of Hemia.....
 - Any evidence of Hemorrhoids
- h) Urine.....albumen.....sugar.....
- i) Any observable physical defects in addition to general records of observation:
 - If any, please specify.....
- j) Is the student on any treatment?.....
 - If any, please specify.....
- k) Blood Khan Test.....
- l) Any other observation of importance.....
 -
 -

Date:.....

Medical Officer

Address:.....

Stamp.

PART III

(To be completed by the University Medical Officer)

Special Remarks.....
.....
.....
.....
.....
.....

Is the Student fit for University Education? Yes / No

Date:.....

Medical Officer

For: MUST