



JOMO KENYATTA UNIVERSITY
OF
AGRICULTURE AND TECHNOLOGY

P.O. BOX 62000-00200, CITY SQUARE, NAIROBI, KENYA. TELEPHONE: (067) 5870001-4

REGISTRATION NO:.....

STUDENTS MEDICAL ENTRANCE EXAMINATION
(TO BE PRINTED ON A4 PAPER)

Students are requested to complete **Part I** of this Form. **Part II** should be completed by the Medical Officer examining the Student. **Part III** of the form shall be completed at the JKUAT Hospital. The completed Form should be brought personally and presented to the **Medical Registration Officers at JKUAT Hospital before/during/ or within one month after the reporting date. No medical reports should be sent by post.**

PART I

- a). Surname Other Names.....
 Date of Birth..... Place of Birth..... Gender Male [] Female []
 Nationality.....Religion..... Marital Status.....
 College.....School/Institute.....
 Name of Parent/Guardian:Address:
 Telephone No:.....
- b). Have you ever been admitted into a Hospital **Yes** [] **No** [] If Yes, state reasons for admission and date

- c). Have you had any of the following illnesses? (Tick appropriately)
- | | | |
|---|----------------|---------------|
| 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 disease of the digestive system? | Yes [] | No [] |
| v). Any disease of Genito Urinary system? | Yes [] | No [] |
| vi). Allergies to food or drugs | Yes [] | No [] |
| vii). Malaria? | Yes [] | No [] |
| viii). Sexually transmitted diseases? | Yes [] | No [] |
| ix). Poliomyelitis? | Yes [] | No [] |



If **YES** to any of the above, Please give details with dates against each of above illness.

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

.....

e). Has any of your family members suffered from:

i). **Tuberculosis** Yes [] No [] ii). **Insanity/Mental Illness** Yes [] No []

iii). **Diabetes Mellitus** Yes [] No [] iv). **Heart Disease** Yes [] No []

f). Have you been immunized against any of the following?

i). **Small pox** 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 EarLeft Ear.....

d) Condition of:

Teeth: Nose: Throat:.....

e) Lymphatic glands:

Circulatory System:

Pulse:

Blood Pressure: Systolic:..... Diastolic:.....

f) Respiratory System.....

.....

X-Ray Chest:.....

g) Hepatitis B Vaccinations:.....

**(THE STUDENT TO BE GIVEN THE X-RAY FILM AND HEPATITIS VACCINATION
CERTIFICATE TO PRESENT TO THE UNIVERSITY CHIEF MEDICAL OFFICER BEFORE
/DURING THE REGISTRATION, OR WITHIN ONE MONTH AFTER THE REPORTING DATE)**

h). Abdomen.....Spleen

Any evidence of Hernia

Any evidence of Haemorrhoids.....



- i) Urine.....Albumin..... Sugar.....
- j) Any observable physical defects in addition to general record of observation.....
- k) Is the student on any treatment? If any, please specify.....
- l) Blood Khan Test
- m) Any other observation of importance:

Medical Officer:**Date:**...

Address:

Stamp

PART III

(To be completed by the University Chief Medical Officer)

Special Remarks:

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Is the Student fit for University Education? **Yes** [] **No** []

Date:

Chief Medical Officer

For JKUAT

Insert Name and Address of Parent/Guardian who should be contacted in case of emergency.

NAME. 1: Relationship:

Telephone No(s):

E-Mail: Date:

NAME. 2: Relationship:

Telephone No(s):

E-Mail: Date:

NB: MEDICAL VERIFICATION CAN BE DONE AT THE UNIVERSITY HOSPITAL BEFORE/DURING REGISTRATION DATE OR WITHIN ONE MONTH FROM THE REPORTING DATE.

