Adullam
RCN Theological Seminary
Contending for the Truth

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MEDICAL REFERENCE FORM

Instructions to Applicants:

This medical form must be completed by a registered medical doctor at a recognized Government or Private hospital, preferably someone who has treated you in the past. It may mean that you must have some laboratory tests done for the form to be completed properly. RCN Theological Seminary will not accept any form from another source. Failure to produce an acceptable medical form will be a reason to deny you admission into the institution.

Instructions to the Doctor:

As part of the admission process, RCN Theological Seminary is seeking to have a full medical record for each student. Please be assured that this information will be treated in the strictest confidence. Please ensure that the form is signed, stamped and in a sealed envelope. Each student will be required to present it during their clearance.

Name of applicant: _____ Male ☐ Female ☐

Next of Kin's Name: _____ Next of Kin's Phone No.: _____

Please indicate past or present illnesses with date, duration and treatment:

Anaemia: _____ Migraine: _____ Hypertension: _____

Asthma/Allergies: _____ HIV test: _____ Kidney disease: _____

Diabetes: _____ Sickle cell: _____ Heart disease: _____

Mental illness: _____ Hepatitis: _____ Muscle/Skeletal problem: _____

Epilepsy/Convulsion: _____ Surgery/hospitalization: _____ Tuberculosis: _____

Gastro-intestinal: _____ Ulcers: _____

Is the patient under treatment for any medical or emotional condition? Yes ☐ No ☐
If yes, please explain: _____

_____

Do you have any recommendation regarding the care of this applicant? Yes ☐ No ☐
If yes, please explain: _____

_____

Is surgery likely to be required for this applicant in the near future? Yes ☐ No ☐

Is the patient under any routine drugs/medication? Yes ☐ No ☐

If Yes, specify _____

Physical Education

Height_____ Weight_____ Pulse_____ Are there any abnormalities in the following systems?

	Yes	No
Head, Ears, Nose, Throat, Hearing.	☐	☐
Eyes/Vision	☐	☐
Respiratory	☐	☐
Cardiovascular	☐	☐
Gastrointestinal	☐	☐
Hernia	☐	☐
Genitourinary	☐	☐
Musculoskeletal	☐	☐
Metabolic/Endocrine	☐	☐
Neuropsychiatric	☐	☐
Skin	☐	☐
Is there loss or seriously impaired function of any organ?	☐	☐

Laboratory Work Required:

Mantoux Skin test for TB. Result: _____

If strongly positive, must have chest X-ray. Result: _____ Please indicate which vaccinations the applicant has had, and the date of vaccinations.

Meningitis: _____ Other: _____ Date: _____

Tetanus: _____ Date: _____

I have examined the above-named applicant whom I have known since _____
From my knowledge of his /her past history, and as a result of my examination of him/her, it is my opinion that he/she is in good health mentally, emotionally and physically, and that he/she will be able to pursue full course of study at your educational institution.

Date of physical examination: _____

Doctor's name: _____

Address: _____

_____

Phone number: _____ Email: _____

_____

Signature Official Stamp