

UNIVERSITY OF PORT HARCOURT

Choba, Port Harcourt



STUDENT MEDICAL REPORT FORM 1

(To be completed by the Student)

Students are required to complete section I of this form with the help of a Doctor who should complete and sign section II

The information being requested for will in no way jeopardise your chance of gaining admission in this University. Rather, it will be in your own interest to answer the questions truthfully about your health. Non-registration at the Medical Centre will result in non-issuance of Matriculation Number.

SECTION I

NAME: **MCDON-EBUO, ALEXIA BELUCHI**
DATE OF BIRTH: **2005-12-07**
SEX: **FEMALE**
MARITAL STATUS: **SINGLE**
RELIGION: **CHRISTIANITY**
COLLEGE/FACULTY: **CLINICAL SCIENCES**
DEPARTMENT: **NURSING SCIENCE**
DEGREE COURSE: **NURSING SCIENCE**
NATIONALITY: **NIGERIAN**
STATE OF ORIGIN: **ENUGU**
LOCAL GOVERNMENT AREA: **EZEAGU**
HOME-TOWN: **EZEMA TOWN**

FATHER'S NAME: **MR. MCDON-EBUO TONY**
FATHER'S ADDRESS: **NO 8 OTUNDA CLOSE**
RUMUAGHOLU ROAD PORT HARCOURT
FATHER'S PHONE: **08061387381**

NEXT-OF-KIN: **MR. MCDON-EBUO TONY**
NEXT-OF-KIN ADDRESS: **NO 8 OTUNDA CLOSE**
RUMUAGHOLU ROAD PORT HARCOURT
NEXT-OF-KIN PHONE: **08061387381**

MEDICAL EXAMINATION TIME/DATE: **7:00 AM / 2024-02-06**

Do you suffer from any of the following conditions?

CONDITION	YES/NO	CONDITION	YES/NO
TUBERCULOSIS		HIGH BLOOD PRESSURE	
EPILEPSY		MENTAL ILLNESS	
DIABETES		ASTHMA	
SICKLE CELL DISEASE		EYE CONDITION	
BLOOD DISEASE			

Are you allergic to any drugs? [YES] [NO]

If yes, please specify _____

Are you presently on any medication? [YES] [NO]

If yes, please specify _____

SIGNATURE _____

DATE _____