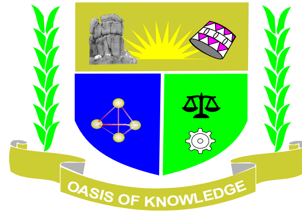

JARAMOGI OGINGA ODINGA UNIVERSITY OF SCIENCE AND TECHNOLOGY
JOOUST CENTRE OF THE TECHNICAL, VOCATIONAL EDUCATION AND TRAINING
OFFICE OF THE REGISTRAR (ACADEMIC AFFAIRS)

Tel. 057-2501804
email: racademic@jooust.ac.ke

P.O. BOX 210 - 40601
BONDO

Date: ____________________

Our Ref:
Your Ref:

STUDENT ENTRANCE MEDICAL EXAMINATION

Admission Number: ____

IMPORTANT

Students are requested to complete part 1 of this form. The Medical Officer examining the student should complete part II. The completed form should be handed to the Registrar, Academic Affairs, Jaramogi Oginga Odinga University of Science and Technology on the day of registration.

PART I

(a) Surname: _______________________ Other Names: ______________________
Date of Birth: ____________________ Place of Birth _______________________
Age:___________________________ Nationality__________________________
Single/Married: ___________________
Faculty: ____

Name, address and telephone number of parent/guardian/next of kin.
____
____
____
____
____

(b) Have you ever been in an in-patient hospital or nursing home? YES/NO. If so when and for what complaints?

____
____
____
____
____

(c) Have you suffered from or had symptoms of any of the following? (Delete as necessary)

Tuberculosis or other chest infection YES/NO

Fits, Nervous disease or fainting attacks YES/NO

Heart disease or Rheumatic fever YES/NO

Any disease of the genitor-urinary system YES/NO

Allergies to food or drugs YES/NO

Malaria YES/NO

Sexually transmitted disease YES/NO

Poliomyelitis YES/NO

Epileptic Attack YES/NO

Any physical detect or deformity YES/NO

Any disease not mentioned above YES/NO

____
____
____
____

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

(d) Is there any other relevant detail of your medical history not covered by the above questions? YES/NO. If yes, please give particulars.

____
____
____
____

(e) Has any member of your family suffered from?

(i) Tuberculosis YES/NO
(ii) Insanity or Medical illness YES/NO
(iii) Diabetes mellitus YES/NO
(iv) Heart Disease YES/NO

(f) Have you been immunized against the following diseases?

(i) Smallpox ______________________ YES/NO Date: _____________________
(ii) Tetanus _______________________ YES/NO Date: _____________________
(iii) Poliomyelitis __________________ YES/NO Date: _____________________

Signature of Student: ______________________________ Date: ______________________

(To be filled by examining Medical Officer)

(a) Height ________________________________ Weight ______________________
(b) Visual Acuity
Without glasses R.6 ________________1.6/ ___________________________
With Glasses R.6/ ________________ 1.6/ ___________________________
(c) Hearing Right ear ____________ Left ear _____________________
(d) Conditions of:
Teeth ________________________________ Throat ______________________
Ears _________________________________ Lymphatic Glands _____________
Nose ________________________________
Abdomen ____________________ Liver _______ spleen __________ Urine ______ Stool _______________________
(e) Circulatory System
Pulse _____________________________________
(f) Doctor's Comment: ____
____
____

Examining Doctor ______________________________ ___________________________

Name **Signature and Rubber stamp**

Date: _____________________