Republic of Kenya

MINISTRY OF EDUCATION

STATE DEPARTMENT OF VOCATIONAL AND TECHNICAL TRAINING

EKERUBO GIETAI TECHNICAL TRAINING INSTITUTE

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MEDICAL EXAMINATION REPORT

STUDENT REG. NO: ----------

IMPORTANT

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

PART I: TO BE COMPLETED BY THE STUDENT

a) First Name…….. Middle Name …… Surname……..

Date of Birth……. Place of Birth……Nationality…… ….

Gender: Male ☐ Female ☐

Religion…… Marital Status…….u

Name of Parent/Guardian/Next of Kin……...

Address of Parent/Guardian/Next of Kin……

Telephone Number of Parent/Guardian/Next of Kin……..

……

b) Have you ever been admitted into a hospital? Yes/No ……..

If so, state reason for admission and date……..
……

c) Have you ever had any of the following illness? (tick as appropriate):

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 genital urinary system	Yes/No
vi)	Allergies to food or drugs	Yes/No
vii)	Sexually Transmitted Disease	Yes/No
viii)	Poliomyelitis	Yes/No

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

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

e) Has any member of your family suffered from any of the following diseases? (tick as appropriate):

i)	Tuberculosis	Yes/No
ii)	Insanity or mental illness	Yes/No
iii)	Diabetes mellitus	Yes/No
iv)	Heart disease	Yes/No
v)	Yellow Fever	Yes/No
vi)	Ebola	Yes/No

f) Do you have any disability (ies)? Yes/No
If Yes, give details……..
…….

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: ……

f) Circulatory system: …….....

Pulse:……..

Blood pressure: Systolic: ……. Diastolic: ……..

g) Respiratory system:……

h) Abdomen: …….....

Spleen: ……Liver…….

Any evidence of Hernia? ……

Any evidence of Hemorrhoids? …….

i) Urine: Albumin: …… Sugar: ……..……SG:…….

j) Any observable physical defects or physical/non-physical disability? **Yes/No**

If any please specify……

……

k) Is the student on any treatment? …….

If any please specify …….....

l) RPR Test…….

m) Describe any other observation of importance:

....……

……

Name of Medical Officer:…… Home Town/City:……

Telephone No:…….. Stamp and date:……