LAIKIPIA UNIVERSITY

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OFFICE OF THE REGISTRAR (ACADEMIC AFFAIRS)
MEDICAL FORM

STUDENT REGISTRATION NO: ……

Note:

1. Students are requested to complete Part I and II of this form. Part III should be completed by the Medical Officer examining the student. The completed form and a copy of both the SHA Card and National ID **MUST** be submitted to the University Medical Officer on the registration day.
2. ALL students are required to have a SHA cover nominating Laikipia University Medical Centre as their preferred outpatient facility. This may be done through their parents/guardians as dependents OR as individual contributors before admission. ONLY students who are below 18 years old OR whose parents/guardians are civil servants can register as dependents while the rest have to enroll as individual contributors.
3. All students are encouraged to ensure that their SHA monthly payments are up-to-date to guarantee continued medical care.
   Any medical services that the student may require outside the University's Medical Centre and the SHA cover are a direct responsibility of the parent/guardian.

PART I: (*To be completed by the student)*

Medical Insurance and Consent

SHA No……..……Relationship with the policy holder (if not self) ……

The undersigned hereby grants permission for medical treatment and care to be provided by Laikipia University Medical Centre:

If above 18 years:

Student's Name: ……. Signature: …… Date……

If below 18 years at the time of admission:

Name of Parent/Guardian: …… Signature: ……

Relationship: …… Date……..……

PART II (***To be completed by the student)***

a) Bio Data:

Name: …… …… ……

First *Middle* *Surname*

Date of Birth: ……Sex: …….

(DD/MM/YYYY)

Name of Next of Kin: ……Relationship……

Postal Address……Telephone Number……

b) Medical History:

i) Kindly indicate whether you or anyone in your family has ever suffered from any of the following conditions (Circle as appropriate):

Disease	**Self**		**Family**	
Tuberculosis	Yes	No	Yes	No
Epilepsy	Yes	No	Yes	No
Mental Illness	Yes	No	Yes	No
Hypertension	Yes	No	Yes	No
Diabetes Mellitus	Yes	No	Yes	No
Cancer	Yes	No	Yes	No
***Others (if any)**	Yes	No	Yes	No

*If Yes, kindly give details:

……..……

……..……

Have you ever been hospitalized? ☐ Yes ☐ No. If yes, give details and dates and sickness/condition involved.

……..……

……..……

Have you ever had a surgical procedure? ☐ Yes ☐No. If yes, give details of dates and condition involved.

……..……

……..……

Have you ever suffered any serious accident? ☐ Yes ☐ No. If yes, give details.

……..……

……..……

Do you have any physical disability? ☐ Yes ☐ No. If yes, give details.

……..……

……..……

<u>PART III</u> (*To be completed by the examining Medical Officer/Clinical Officer)*

General Observations:

Height……..…Weight……BMI……

Blood Pressure……Pulse…….

Eye: Visual Acuity……..…Pupils……..……..…

Ears: Right…….……Left ……..…

Nose and Throat…….……

Teeth…….……..…

Cardiovascular System:

Heart Sounds……..…….……..……

Heart Murmurs……..…….……..……

Blood Sugar……

Respiratory System:

Chest **(MUST include geneXpert test)** ……

Tuberculosis or chest complains ☐ Yes ☐ No. Please give details……..

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Abdomen: ……

Nervous System: ……

Mental State Exam: ……..……

Genital Exam: ……

Musculoskeletal……

Skin: ……

Any other serious illness or operation ☐ Yes ☐ No. Please give details……

……

DECLARATION BY THE EXAMINING MEDICAL OFFICER/CLINICAL OFFICER

I have examined ….…… and observed that:

Name of Student

a) He/she is fit for studies. **YES** ☐ **NO** ☐

b) His/her state of health will not affect their studies adversely. **YES** ☐ **NO** ☐

In case of a **NO** response in a) and or b**)** above, Give details

……..……

……..……

c) Name of Health Officer: ……

Health Facility: ……

Signature……**Date**…….

Official Stamp

FOR OFFICIAL USE

Recommendation by the University Medical Officer

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Name: ……Signature:……...Date……....…….....

Official Stamp