SHIFAH MEDICAL TRAINING COLLEGE
P.O BOX 37-40308, AMBWERE PLAZA, KITALE, KENYA.
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MEDICAL EXAMINATION FORM

PART I: TO BE COMPLETED BY THE PERSON BEING EXAMINED

Surname:_____ **Middle Name:**_____ **First Name:**_____ **Date of Birth:** _____ **Gender: (Tick) Male** ☐ **Female** ☐

(Date) (Month) (Year)

Next of kin:_____ **Relationship:**_____ **Tel:**_____

Have you ever been admitted in a hospital or undergone an operation? Yes ☐ No ☐ If **YES** above, please reason for admission and date

_____

_____

PART II: TO BE COMPLETED BY THE MEDICAL OFFICER EXAMININING THE STUDENT

Has the student ever had any of the following illnesses? (Delete as necessary)

	YES	NO
Tuberculosis		
Seizures/Fainting/ Fits		
Typhoid		
Heart disease or rheumatic fever		
Gastric or Duodenal Ulcers		
Fractures or dislocations		
Food allergy		
Drug allergy		
Any chronic illness (Diabetes, Hypertension (e.t.c)		

If **YES** to any of the above, explain when and how it was treated

_____

_____

PART III: PHYSICAL EXAMINATION

1. Height (in cm) _____ Weight _____ B. P _____ Pulse _____
2. Gait_____ Posture _____
3. Chest Exam_____ Abdominal Exam _____
4. CVS exam_____ MSK exam _____
5. Visual Acuity: Without Glasses: R _____ L _____ With Glasses: R _____ L _____
6. Hearing: Right ear_____ Left ear _____
7. Teeth _____
8. Lymphatic Glands _____

PART IV: LABORATORY TESTS

1. Urinalysis_____
2. Pregnancy Test _____ L.M.P_____

I declare that I have examined the above student and he/she is fit to join College. Yes ☐ No ☐

Name of Officer_____ **Designation**_____ **Date** _____ **Signature**_____ **(Stamp)**