BLUE PHARMA COLLEGE OF HEALTH

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P.O.Box 1570,
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MEDICAL EXAMINATION FORM

To: The Medical Officer In charge
_____ (Name of the Health facility)
_____ (Postal address)
_____

REF: REQUEST FOR MEDICAL EXAMINATION OF THE STUDENT PRIOR TO JOINING THE COLLEGE

STUDENT'S PERSONAL INFORMATION

Name of the student: _____
Age: _____
Sex: _____
Marital Status: _____
Citizenship: _____

PAST MEDICAL HISTORY

Any recent experience of loss of consciousness (YES/NO): _____
Any neurological deficit disorder (YES/NO) If Yes specify: _____
Any recent experience of Fits/Convulsion (YES/NO) _____

CHRONIC ILLNESSES

Diabetes Mellitus (YES/NO) If Yes when diagnosed: _____

Current status: On diet ☐ On medication ☐ Not on medication ☐

Any other cardiovascular conditions (YES/NO) If Yes specify: _____

Asthma (YES/NO) If Yes, approximately how many attacks per months: _____

Current status: on medication ☐ not on medication ☐

Any mental illness YES/NO, If Yes On medications ☐ not on medications ☐

Any allergy (YES/NO) If YES specify the allergen(s) _____

Tuberculosis (YES/NO) if yes; cured ☐ on treatment ☐ not on treatment ☐

Leprosy (YES/NO) if yes; treated ☐ on treatment ☐ not on treatment

Any other chronic disease(s): _____

PHYSICAL EXAMINATION: (Please examine the students regarding the following parameters and write results/ observations against each one)

SN	Parameter to be examined	Results/observations
i.	Height (m)	
ii.	Weight (Kg)	
iii.	Any skin diseases?	
iv.	Sight (Right and left)	
v.	Condition of ears, Mouth and throat	
vi.	Blood pressure (mmHg)	
vii.	Any heart murmur?	
viii.	Liver function	
ix.	Kidney Function	
x.	Any evidence of gastric or duodenal ulcers?	
xi.	Pregnancy test (for females)	
xii.	VDRL	
xiii.	X ray examination (Chest)	

MEDICAL OFFICER CONCLUSION

I have examined Mr/Miss/Mrs.: _____ and hereby declare that he/she is **fit/Not fit** (Cancel whoever not applicable) to be admitted to Blue Pharma College of Health to pursue the program he/she was selected to.

Medical officer's comments (if any)

_____

_____

_____

_____

_____

Name of the Medical officer: _____

Signature_____ Date: _____

Official stamp

IMPORTANT TO NOTE:

i. This form is meant to provide the College administration with information regarding wellness of a student and ensure that those with chronic illness which may require special health attention/consideration are treated accordingly.

ii. This form shall be accepted by the College administration only if filled-in by a Registered and Licensed Medical officer with office stamp at the end.

iii. The health information written in this form shall be treated with great privacy and shall not be used by College administration to discriminate or bully a student.