BLUE PHARMA COLLEGE OF HEALTH

(BPHACOH)

P. O. Box 1570, Singida, Tanzania

Tel: +255 (26)2502524, Mobile: 0742 613 543, 0714 355 029

E-mail: info@bphacoh.ac.tz

Website: www.bphacoh.ac.tz

COLLEGE REGISTRATION NUMBER: REG/HAS/187

STUDENTS'S MEDICAL EXAMINATION FORM

To the Medical Officer:

……

……

REF: Mr/Mrs/Miss ……

PERSONAL INFORMATION

Surname …… Other names ……

Adm. No……

Faculty / Department ……

Nationality…… Age…… Sex…… Marital Status……

Please examine the above named as to his/her fitness for undergoing the studies.

Signature: …… Date …… 20……

PAST MEDICAL INFORMATION

Any experience of loss of consciousness YES/NO If Yes treatment……

Any neurological deficit YES/NO, If Yes specify……
Treatments ……

Any experience of Fits/Convulsion YES/NO, If Yes treatments ……

CHRONIC ILLNESSES

Diabetes Mellitus YES/NO, If Yes when diagnosed .....

Current status: On diet ☐ On medication ☐ On insulin ☐ Not controlled ☐

Cardiovascular conditions YES/NO, If Yes specify .....

Asthma YES/NO, If Yes how many attacks per months .....

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

Any allergy YES/NO, If YES specify .....

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

1. Height ..... Weight.....

2. Chest: Lungs.....

Heart .....

BP .....

3. Abdomen

Organs .....

Other Mass .....

Pregnancy .....

4. Skin disease .....

5. Eyes: Conjunctiva .....

Pupils .....

Sight: Without glasses Right ..... Left .....

Sight: With glasses Right ……. Left …….

6. ENT……..……

INVESTIGATIONS

a) ESR …….. WBC ……. B/S …….. Stool…….. Urinalysis ……..VDRL ……

b) Human Immunodeficiency Virus Test (optional) ……

Any Physical disability of the Prospective student plus the Doctors recommendations

……

CONCLUSION

I have examined Mr./Mrs./Miss …….. and considered that he/she is **fit/not fit** to be enrolled as a student at BPHACOH.

Name ……..……..

Signature…….

Title …….. Designation ……..……

Date ……..…

(Official Stamp)

This form must be filled with a registered medical officer