



Knowledge is Wealth (*Sapientia divitiarum*) Akili ni Mali

MEDICAL DEPARTMENT

Telephones: 020-2310512/18

P. O. Box 109-60400, Chuka

Contact No: 0800230009

Email: medical@chuka.ac.ke,

Website: www.chuka.ac.ke

STUDENT'S MEDICAL BIODATA FORM

Admission/Registration No:

IMPORTANT.

1. Please note that any medical services that the Student may require outside the University's Medical Department is the direct responsibility of the Parent/Guardian.

PART I. TO BE FILLED BY THE STUDENT

Name of the Student:

First: Middle: Last/Surname:

Gender: Nationality: Religion:

Faculty: Marital Status:

Mobile Number:

Parent/Guardian/Next of Kin

Name:

Address: Mobile No.:

Have you ever been admitted to hospital? **YES/NO**

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

Have you any of the following illness? (Circle where appropriate)

- a. Tuberculosis of the Chest infection **YES/NO**
- b. Fits, nervous disease or fainting attacks **YES/NO**
- c. Allergies to food or drugs **YES/NO**
- d. Diabetes Mellitus **YES/NO**
- e. Mental illness **YES/NO**
- f. Asthma **YES/NO**

If the answer to any of the above is **YES**, please give details and

dates.....

If there are any relevant details of your medical history not covered by the above questions, please give particulars

Date Signature

PART II: OFFICIAL USE

Payment of **Ksh.500** medical examination fee to be confirmed and verified by Chuka University Medical Records Officer.

Verified by:

Name **Date**.....

PART III: STUDENT MEDICAL EXAMINATION. (OFFICIAL USE)

(TO BE COMPLETED BY CHUKA UNIVERSITY MEDICAL OFFICER)

Vision:

Hearing:

Circulatory System:

Pulse:

Blood pressure: Systolic: Diastolic:

Heart:

Chest examination and TB screening

.....
.....

If any problem, give details:

.....

Any other observation of importance

.....

Is the student fit for University Education? **YES / NO**

Signature: Date:

Official Stamp: