# KISII NATIONAL POLYTECHNIC

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KISII

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## MEDICAL REPORT

**Name of Student:** _____**Adm. No:** _____
**Training Department**_____**Tel. No**. _____
**Course Enrolled:** _____

**Year of Study:** First [ ] Second [ ] Third [ ]
**Residence Status:** Boarder [ ] Day Scholar [ ]
**Date of Birth:** _____ **Gender:** _____ **Nationality**: _____
Name, Address & Telephone of Parent/Guardian/Next of Kin: _____
_____

**IMPORTANT NOTICE FOR STUDENT**
Before you complete the medical history questionnaire (part A), you are hereby notified that; a medical condition resulting from undisclosed pre-existing condition may result in termination of your study programme at the Kisii National Polytechnic.

I understand and accept terms of this notice Yes ☐ No ☐

**PART A: TO BE FILLED BY STUDENT**

Check (√) YES or **NO** and explain

| No | YES | NO | QUESTION DETAILS | EXPLANATION |
|---|---|---|---|---|
| a | | | Have you had any serious illness or injury (if hospitalised, give place and details)? | |
| b | | | Have you had an operation or advised by physician to have an operation? | |
| c | | | Do you currently use any drugs for treatment of a medical condition (give name and dose)? | |
| d | | | Have you ever been a patient in a mental hospital or treated by a psychiatrist? | |

Do you have or have you ever had the conditions listed below?

| YES | NO | CONDITION |
|---|---|---|
| | | Asthma or other lung conditions |
| | | Tuberculosis(TB) or live with anyone with TB |
| | | High blood pressure or heart disease |
| | | Diabetes (sugar in urine) |
| | | Depression, attempted suicide, excess worry |
| | | Acquired Immune Deficiency Syndrome (AIDs) |
| | | Tumour, abnormal growth, cancer |
| | | Bleeding disorder, blood disease (sickle cell anaemia) |
| | | Kidney disease, blood in urine |
| | | Hearing problems |
| | | Eyesight problems |

**PART B: To be completed by the Medical Examiner**
BODY WEIGHT: _____ HEIGHT: _____

BLOOD ANALYSIS

TOTAL WBC _____ /MM3

EUSINOPHIL _____ %

E.S.R. _____ MM/HR

LYMPHOCYTES _____ %
NEUTROPHIL _____ %
MONOCYETES _____ %

V.D.R.L. _____

CARDIOVASCULAR SYSTEM

PULSE RATE _____ /MIN. RHYTHM _____

BP _____MM/HG

HEART SOUND _____

RESPIRATORY SYSTEM CX-RAY

ABDOMEN

Spleen _____

NERVOUS SYSTEM

Liver _____

Kidney _____

Any Mental Disorders (*tick one*) YES/NO

Family History of Mental Disorders (*tick one*) YES/NO

EYES

Normal (*tick one*) YES/NO

Visual/Acuity Left Eye _____

Right Eye _____

EARS

Normal (*tick one*) YES/NO

Any Discharge (*tick one*) YES/NO

URINE ANALYSIS

Urine Sed _____

Urine Protein _____

STOOL ANALYSIS; Stool for Ova (*tick one*) YES/NO _____

PHYSICAL DISABILITIES (give details)

_____
_____
_____

**NOTE:** I have read and understood the consequences of the contents of this form and I confirm the details I have given are true to the best of my knowledge.

Student Name: …… ……
……. …… …..

Surname Middle name First nam

Contact (Mobile): _____
Signature_____Date_____

**PART C: TO BE FILLED BY PARENT/GUARDIAN/SPONSOR**

Which hospital do you prefer for referral (admission) purposes if need arises?

Name of private hospital in Kisii: _____

Name of public hospital in Kisii: _____

b) Do you have a personal or family doctor?

Yes No

If YES state name and contacts_____
_____

c) Do you agree to pay any costs incurred by your child in any hospital (other than that in "**a**" above) if need be? Yes No

Who can we contact in case of emergency?

Name: _____
Address: _____
Tel Number: _____
Mobile Number: _____
Email: _____

Parent/Guardian: …… ……
……. ……. ……

Surname Middle name First name

Tel Number: …….. Mobile Number: ……

Email: _____

Signature_____Date_____

**PART C: OFFICIAL USE (To be filled by the Clinical Officer)**

Special Remarks:
_____

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Name: _____ Signature: _____ Date: _____