THOMAS ADEWUMI
UNIVERSITY,
OKO, KWARA STATE
Science | Technology | Medicine

STUDENT MEDICAL FORM

The details on this form are confidential and are for the attention of the University Medical Officer only. The form should be returned to the University Medical Officer.

Name of student: .....
(Surname) (First name) (Other names)

Age: ..... Date of Birth: .....

General Health

Please record the following details:

	Date examined	Location	Result	Date of next check up
Eyes				
Teeth				
Ears/Nose/Throat				

Immunization and Inoculations

Please attach a copy of immunization cards / certificates
Have you gotten the following and when (with date)?

Immunization	
Measles	
Polio	
Tetanus	
Typhoid	
Yellow fever	
Hepatitis B	
Human Papilloma Virus	

ALLERGY

Any drug Allergies? .....
Any Food Allergies? .....

Medical History

Have you been diagnosed by a medical practitioner with the following:

- Sickle Cell Anaemia ……
- Asthma ……
- Seizure disorder ……
- Hypertension/Heart Condition(s) ……
- Diabetes Mellitus ……
- Peptic Ulcer Disease (PUD) ……
- Mental ill-health ……
- Others (State the Medical Condition)……

If any of the above is "**yes**", give further details here……
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- Any Previous Surgery? ……
- Any Previous blood transfusion? ……
- Are you on any routine medications? ……
- Any Family history of Hypertension (High Blood Pressure) or Heart condition, Diabetes mellitus, mental ill-health? ……

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Emergency Contact Details

Please write below the contact details of two relatives/Next of kin who may be contacted in the event of an emergency.

Contact 1:
Name ……
Relationship to you: ……

Contact address ……

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Email address……Phone no……

Contact 2:
Name ……

Relationship to you: …… Contact address: ……

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Email address: …… Phone no……

To be filled by a Medical Doctor

Physical Examination

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Chest

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Cardiovascular System

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Abdomen

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Urogenital System

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Central Nervous System

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Musculoskeletal System

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INVESTIGATIONS

Chest X-ray: ……..
Attach a report with the X-ray film

Blood Group ……
Genotype ……..
PCV…….
Urinalysis……
HIV……..
Hepatitis C……..
Hepatitis B……
Fasting Blood Sugar (FBS)…….
Stool microscopy……
Please attach your investigation results.

Any other vital information we should know?
Additional Information: ……..

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Family Doctor

Name of Family Doctor.....

Contact Address ……
……

Email address: …….. Phone no: ……

Certification

I declare that the information enclosed is to the best of my knowledge true and correct.

Signed: …… Student
Date: ……

Signed: …….. (Parent/Guardian)
Date: ……..

Doctor's Certification

I declare that I have reviewed and examined Miss/Mr……
…… and have read this form and that all the information recorded is to the best of my knowledge true and accurate.

Signed: …… Family doctor Date: ……