



# MASENO UNIVERSITY

## OFFICE OF THE REGISTRAR – ACADEMIC AND STUDENT AFFAIRS

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Private Bag,  
 MASENO - Kenya

### STUDENT ENTRANCE MEDICAL EXAMINATION

ADM. NO: \_\_\_\_\_

### IMPORTANT

Students are requested to complete part 1 of this form. The Medical Officer examining the student should complete part II. The completed form should be forwarded to the **Registrar, Academic Affairs, Maseno University PRIVATE BAG MASENO. 40105.**

### **PART I**

(a) Surname: \_\_\_\_\_ Other Names \_\_\_\_\_

Date and Place of Birth \_\_\_\_\_

Nationality \_\_\_\_\_

Faculty \_\_\_\_\_

Single/Married \_\_\_\_\_

Name, Addresses and Telephone number of Parent/Guardian/Next of Kin

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

NHIF NO \_\_\_\_\_

(b) Have you ever been in an in-patient hospital or nursing home? **YES/NO.** If so when and for what complaints?

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- (c) Have you suffered from or had symptoms of any of the following (Delete as necessary).

i.	Tuberculosis or other chest infection	YES/NO
ii.	Fits, Nervous disease or fainting attacks	YES/NO
iii.	Heart Disease or Rheumatic fever	YES/NO
iv.	Any diseases of the digestive system	YES/NO
v.	Any disease of the Genital-Urinary System	YES/NO
vi.	Allergies to food or drugs	YES/NO
vii.	Malaria	YES/NO
viii.	Sexually Transmitted Disease	YES/NO
ix.	Poliomyelitis	YES/NO
x.	Any physical defect or deformity	YES/NO
xi.	Any disease not mentioned above	YES NO

If the answer to any of the above is yes, please give details with dates.

- (d) Is there any other relevant details of your Medical History not covered by the above questions? **YES/NO** if yes, please give particulars

- (e) Has any member of your family suffered from:

(i)	Tuberculosis?	YES/NO
(ii)	Insanity or Mental illness?	YES/NO
(iii.)	Diabetes mellitus?	YES/NO
(iv)	Heart Diseases?	YES/NO

- (f) Have you been immunized against the following diseases?

(i)	Smallpox.....	YES/NO	Date.....
(ii)	Tetanus.....	YES/NO	Date.....
(iii)	Poliomyelitis.....	YES/NO	Date.....

Signature of student \_\_\_\_\_

Date \_\_\_\_\_

**PART II** (To be filled by examining Medical Officer)

(a) Height \_\_\_\_\_ Weight \_\_\_\_\_

(b) **VISUAL ACUITY**

Without glasses R.6/ \_\_\_\_\_ 1.6/ \_\_\_\_\_

With glasses R.6/ \_\_\_\_\_ 1.6/ \_\_\_\_\_

(c) Hearing Right Ear \_\_\_\_\_ Left Ear \_\_\_\_\_

(d) **Conditions of:**

Teeth \_\_\_\_\_ Throat \_\_\_\_\_

Ears \_\_\_\_\_ Lymphatic Glands \_\_\_\_\_

Nose \_\_\_\_\_

(e) **CIRCULATORY SYSTEM**

Pulse \_\_\_\_\_

Examining Doctor \_\_\_\_\_

Signature &amp; Rubber Stamp

Date \_\_\_\_\_

*Submit in quadruplicate (Fill in 4 copies)*