

# GREAT LAKES UNIVERSITY OF KISUMU

## STUDENT MEDICAL REPORT



Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_  
Country \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_  
Weight \_\_\_\_\_ Date of Birth \_\_\_\_\_

This Student Medical Report is part of your admission application procedure in Great Lakes University of Kisumu and should be completed and returned to the office of the Registrar Academics. Your admission cannot be cleared until this form is received. The information contained on this form is kept on file for your protection. You are expected to report fully on the state of your physical condition.

1. Do you or have you ever had any of the following conditions: (if yes, explain)
  - a) High Blood Pressure \_\_\_\_\_
  - b) Stomach Ulcers \_\_\_\_\_
  - c) Diabetes \_\_\_\_\_
  - d) Hernia \_\_\_\_\_
  - e) Nervous or emotional illness \_\_\_\_\_
  - f) Epilepsy or fainting spells \_\_\_\_\_
  - g) Psychiatric treatment \_\_\_\_\_
  - h) Asthma \_\_\_\_\_
  - i) Tuberculosis or lung disease \_\_\_\_\_
2. Give the date of your last primary immunization \_\_\_\_\_
3. Have you had any serious accident or injury in the last five years? \_\_\_\_\_
4. Do you suffer from any physical disability? \_\_\_{ \_\_\_\_\_
5. Are you presently under the care of a physician? \_\_\_\_\_
6. Do you take medication on a regular basis? \_\_\_\_\_
7. Are you allergic to any types of medication? \_\_\_\_\_
8. Do you have any communicable disease or condition that would pose a threat to others with whom you come into contact? \_\_\_\_\_

if your answer to any of the above questions is YES, please give details.

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9. Do you have current insurance cover? If so give the name \_\_\_\_\_

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**Medical examination by registered practitioner** [Please list any other pertinent information regarding status of health]

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Name of Physician \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

Country \_\_\_\_\_

Day Phone (    )

Evening Phone (    )

**TO BE COMPLETED BY STUDENT:**

I hereby affirm that all information supplied on this medical report is complete and accurate to the best of my knowledge. I understand that withholding information requested or giving false information may make me ineligible for housing and is reason for dismissal. I also give permission to a local attending physician to administer to me any medical aid deemed necessary.

Student's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**TO BE COMPLETED BY PARENT OR GUARDIAN OF A STUDENT UNDER THE AGE OF 19:**

In the case of an emergency and/or upon recommendation of a local physician that hospitalization is necessary to the welfare of my son/daughter, the College has my permission to admit him/her to the nearest hospital. The attending physician also has my permission to contact my son's/daughter's physician about his/her medical history and to administer any medical aid deemed necessary.

Parent's/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR OFFICIAL USE ONLY**

Date form received \_\_\_\_\_

Verified by \_\_\_\_\_

Authorized Signature \_\_\_\_\_

**DVC-ACADEMIC AFFAIRS/REGISTRAR ACADEMICS/DEAN OF STUDENTS**