STUDENT MEDICAL EXAMINATION OF FITNESS FOR ADMISSION

Students are requested to complete Part I of this form and have Part II completed by Medical Doctors in any Public Health Institution and Part III completed by Medical Officers in the University Health Centre on presentation of Medical clearance fee of One Thousand Four Hundred Naira (₦1,400.00) only. Chest X-Ray should be taken only at the University Health Centre.

PART I (TO BE FILLED IN BY THE STUDENT)

Surname:...............................................................................................................

State of Origin: ..................................................................................................

Age Next Birthday:..........................................................................................

Sex:.......................................................................................................................

Marital Status:...................................................................................................

Nationality:...........................................................................................................

Tribe:....................................................................................................................

Department:........................................................................................................

Course:.................................................................................................................

(a) Would you say your Health is Good/Fair/Poor?

(b) Have you ever been admitted as an in-patient into a hospital?

If so please state reason for admission:

(c) Have you ever visited any hospital for treatment? Yes/No

if yes, purpose of visit

(d) Do you suffer from or have you suffered from any of the following?

Tuberculosis Yes/No

Nervous disease Yes/No

Schistosomiasis Yes/No

Any disease of the heart Yes/No

Any respiratory disease e.g Bronchia Yes/No

Genitorurinary System Yes/No

Asthma

Any disease of the digestive system Yes/No

Allergies Yes/No

Any Nasal Bleeding Yes/No

If one answer to any of the above is Yes, Please give details and Date:

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

(f) Is your family a healthy one? Has any member of your family suffered from tuberculosis, insanity or mental disease?

(g) Have you been immunized against any of the following?

Tetanus Date:

Yellow Fever Date:

Polio Date:

Others Date:
**PART II: TO BE COMPLETED BY A MEDICAL OFFICER IN ANY PUBLIC HEALTH INSTITUTION**

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<thead>
<tr>
<th>Height</th>
<th>Weight</th>
<th>Visual Acuity:</th>
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<td>With Glasses</td>
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**Ears**
- Circulatory System
- Heart
- Blood Pressure

**Eyes**
- Pharynx
- Respiratory system
- Teeth
- Lungs
- Lymphatic Glands
- Abdomen
- Liver
- Spleen
- Hernia

**C.N.S**
- Pupillary reflexes
- Spinal reflexes

**Screening for:**
- Hepatitis B
- Hepatitis C
- VDRL
- Urine:
  - PH:
  - Blood group:
- PCV:
- Blood group:
- Protein:
- Genotype
- Glucose:
- Nitrite:
- Others:

*Snellens or similar test should be used.*

**Date:** ........................................
**Medical Officer (Name):** ........................................

**Address:** ........................................

*Signature & Date*

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**PART III: TO BE COMPLETED BY A MEDICAL OFFICER IN LAUTECH UNIVERSITY HEALTH CENTER***

**Tuberculin Test (Mantoux with report)**

**RVS (Optional):**

**Chest X-Ray with Radiologist Report**

**Remarks:** ........................................

**Final Assessment of Health:** ........................................

*Signature of Medical Officer*