Every fresh student is requested to complete part I of this form and report promptly at the University Health Centre after securing admission. You will need to pay for, and have your Chest Radiology and Medical Laboratory investigation done. Finally, you are to present the Chest X-Ray film and results of the Laboratory Test to a Medical Officer at the University Health Centre for completion of form II and III, having paid the additionally required One thousand four hundred naira (N1,400) for your Medical Clearance Certificate.

PART I (TO BE FILLED BY THE STUDENT)

Surname: ……………………… Other names: …………………………………………
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 an hospital? Yes/No: ………
If Yes, please state reason for admission: …………………………………………………
……………………………………………………………………………………………………

(C) Have you ever visited any hospital for treatment? Yes/No……………………...
If Yes, state reason for treatment…………………………………………………………
……………………………………………………………………………………………………

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

Tuberculosis Yes/ No Nervous Diseases Yes/No
Schistosomiasis Yes/No Any diseases of the heart ? Yes/No
Any respiratory diseases e.g Bronchia Yes/No genitourinary Yes/No
Asthma Yes/No System
Any diseases of digestive system Yes/No
Any nasal bleeding Yes/No

If one answer to any of the above is Yes, please give details and Date……………………
……………………………………………………………………………………………………

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

Is your family a healthy one? Yes/No
Has any member of your family suffered from insanity or mental illnesses? Yes/No

Have you been immunized against any of the following?

Tetanus…………………… Date……………………
Yellow Fever…………………… Date……………………
Poliomyelitis…………………… Date……………………
Others…………………… Date……………………
PART II TO BE COMPLETED BY A MEDICAL OFFICER IN LAUTECH HEALTH CENTRE

<table>
<thead>
<tr>
<th>Height (Meter)</th>
<th>Weight (KG)</th>
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<tbody>
<tr>
<td></td>
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</table>

Visual Acuity:

<table>
<thead>
<tr>
<th>Without Glasses</th>
<th>Without glasses</th>
<th>R.6/</th>
<th>L.6/</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eyes</td>
<td>Ears</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Left Eyes
- Right Eyes
- Pharynx
- Teeth
- Lymphatic Glands

C. N. S
- Pupillary Reflexes
- Spinal Reflexes

Screening for:

- Hepatitis B
- Hepatitis C
- VDRL

<table>
<thead>
<tr>
<th>Urine</th>
<th>PCV</th>
<th>Blood Group</th>
<th>Genotype</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>Protein</td>
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<td>Glucose</td>
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<tr>
<td>Nitrite</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Others</td>
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<td></td>
</tr>
</tbody>
</table>

Date: .....................
Address: ..............................................................
..............................................................
..............................................................

..............................................................
Signature & date
Snellens or similar test should be use

PART III: TO BE COMPLETED BY A MEDICAL OFFICER IN LAUTECH HEALTH CENTRE

- Tuberculin Test (Mantoux with report)
- RVS (Optional):
- Cest X Ray with Radiologist Report

Remarks: ..............................................................
..............................................................

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

..............................................................
Date ..............................................................
Signature of Medical Officer