

KIRINYAGA UNIVERSITY

P.O BOX 143-10300 KERUGOYA TEL 0709742000-30

OFFICE OF THE REGISTRAR (ARSA)

Email-academics@kxu.ac.ke

REG. NO.....

STUDENT MEDICAL FORM

IMPORTANT

- Students are requested to complete part 1 of this form
- Part II should be completed by the Medical Officer examining the student.
- The duly filled Medical form and the chest X-ray radiologist report should be uploaded on the online Admission portal. Hard copies of the same should be presented to the Medical Registration Officers on the day of registration

Surname.....

Date of Birth.....

Phone no.....

Course

Name, A.....

Have you ever been admitted into a Hospital? NOIf so, state reason for admission and date..... NO

Do you suffer from / or are you on treatment for any of the following illnesses?

- Tuberculosis, Asthma or other chest infections? Yes/NO
- Fits, nervous disease or fainting attacks? Yes/NO
- Heart disease or Rheumatic fever? Yes/NO
- Any chronic disease? Yes/NO
- Allergies to food or drugs? Yes/NO
- Sexually transmitted diseases? Yes/NO
- Physical disability Yes/NO

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

NO

If there are any relevant details of your medical history not covered by the above questions, Please give particulars.....

NO

Is there any history of chronic familial diseases such as?

- Hypertension? Yes/NO
- Diabetes Mellitus? Yes/NO
- Asthma? Yes/NO
- Any other specify NO

Have you been immunized against any of the following diseases?

- Tuberculosis? Yes/NO Date: 21/7/2028
- Tetanus? Yes/NO Date: 21/7/2028
- Poliomyelitis? Yes/NO Date: 21/7/2028

PART II
(To be completed by the Examining Medical Officer)

a) Height..... Weight..... BMI.....

b) Visual Acuity:

Without Glasses R.....

With Glasses R./L.....

c) Hearing: Right ear.....

d) Condition of:

Teeth:.....

Nose.....

Throat.....

(e) Lymphatic glands.....

(f) Circulatory system.....

Blood pressure.....

(g) Respiratory System.....

Chest X ray (man.....

(THE STUDENT TO BE
DURING ADMISSION)

h) Abdomen.....

i) Urine..... NA

j) Is the student on any.....

k) Blood Khan Test.....

l) Any other observation of importance..... NONEDate..... 21/7/2026

Stamp

Medical Officer.....

Data Privacy Notice and Consent

The information provided in this form will be collected and used solely for purpose of Medical assessment, treatment, referral and student health records. All medical information will be collected by personnel except where disclosure is in accordance to policy.

- ☒ YES - I consent to the collection, use, storage and processing of my personal and health data by University Medical Services for health care, referral and lawful reporting purposes
- ☒ NO - I do not consent to use of my personal and health data as stated above.

Student Reg No.....

For students Below 18 years

I the undersigned

provide consent

Parent /Guardian