



ADM No.:

## KENYA INSTITUTE OF MASS COMMUNICATION

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### MEDICAL REPORT

Student Name: .....

Surname

First Name

Middle Name

Adm. No: ..... Year of Study: First [ ] Second [ ] Third [ ]

Training Department: ..... Tel. No. ....

Course Enrolled: .....

Mode of Study: Day [ ] Evening [ ] Residence Status: Boarder [ ] Day Scholar [ ]

Date of Birth: ..... Gender: ..... Nationality: .....

Name &amp; Address Parent/Guardian/Next of Kin: .....

### IMPORTANT NOTICE FOR STUDENT

*Before you complete the medical history questionnaire (part A), you are hereby notified that; a medical condition resulting from undisclosed pre-existing condition may result in termination of your study programme at the Kenya Institute of Mass Communication.*

I understand and accept terms of this notice Yes  No

### PART A: TO BE FILLED BY STUDENT

Check (✓) YES or NO and explain

No	YES	NO	QUESTION DETAILS	EXPLANATION
a			Have you had any serious illness or injury (if hospitalised, give place and details)?	
b			Have you had an operation or advised by physician to have an operation?	
c			Do you currently use any drugs for treatment of a medical condition (give name and dose)?	
d			Have you ever been a patient in a mental hospital or treated by a psychiatrist?	

Do you have or have you ever had the conditions listed below?

YES	NO	CONDITION
		Asthma or other lung conditions
		Tuberculosis(TB) or live with anyone with TB
		High blood pressure or heart disease
		Diabetes (sugar in urine)
		Depression, attempted suicide, excess worry
		Acquired Immune Deficiency Syndrome (AIDs)
		Tumour, abnormal growth, cancer
		Bleeding disorder, blood disease (sickle cell anaemia)
		Kidney disease, blood in urine
		Hearing problems
		Eyesight problems

**NOTE:** I have read and understood the consequences of the contents of this form and I confirm the details I have given are true to the best of my knowledge.

.....

**Student's Signature** **Date**

**PART B: TO BE FILLED BY PARENT/GUARDIAN/SPONSOR**

a) Which hospital do you prefer for referral (admission) purposes if need arises?

Name of private hospital in Nairobi: .....

Name of public hospital in Nairobi: .....

b) Do you have a personal or family doctor?    Yes        No   

If YES state name and contacts: .....

c) Do you agree to pay any costs incurred by your child in any hospital (other than that in "a" above) if need be?    Yes        No   

d) Who can we contact in case of emergency?

Name: .....

Address: .....

Tel Number: .....    Email: .....

Parent/Guardian: .....

Surname

Middle name

First name

Tel Number: ..... Email: .....

.....

**Parent/Guardian's Signature**

**Date**

**PART C: OFFICIAL USE (To be filled by officer in-charge of medical services)**

KIMC Medical Officer's Remarks:

\_\_\_\_\_

\_\_\_\_\_

Is the student fit for the KIMC education? Yes  No

Certified and processed by:

**Medical Officer:** .....

Surname

Middle name

First name

.....

**Signature**

**Date & Stamp**

***NB:** Any health related requirements that apply to students at KIMC, should be addressed to the Director, KIMC and signed off by a registered medical practitioner.*