ADM No.:

KENYA INSTITUTE OF MASS COMMUNICATION
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MEDICAL REPORT

Name of Student: _____ **Adm. No:** _____

Training Department_____ **Tel. No.** _____

Course Enrolled: _____

Year of Study: First [ ] Second [ ] Third [ ]

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

Date of Birth: _____ **Gender:** _____ **Nationality:** _____

Name, Address & Telephone of 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 Name: ....

Surname Middle name First name

Contact (Mobile): _____

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: _____

Mobile Number: _____

Email: _____

Parent/Guardian: ....

Surname Middle name First name

Tel Number: ..... Mobile Number: .....

Email: _____

Signature_____Date_____

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

Special Remarks: _____

_____

Is the student fit for the KIMC education? Yes ☐ No ☐

Name: _____ Signature: _____ Date: _____

***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.*