MEDICAL EXAMINATION FORM

NAME: 
ADMISSION NUMBER: 
AGE: SEX: WEIGHT: HEIGHT: 
Skin: Note: Presence of any contagious skin disease e.g. Ring worms

Allergies: 

Mouth & Teeth:
Cavities: 
Occlusion (Normal and maloccluded):
Eyes: Mandatory
Visual acuity L/E: R/E: 
Visual Field: Colour Blindness: 

ENT:
Hearing Left Ear: Right Ear:
Impairment: 
Smelling Defects: 

Cardiovascular System:
Blood Pressure: 
Pulse Rate: 
Heart Sound: 

Respiratory System:
Asthma: 
Allergies: 
BCG Scar: 

Recommendations
I certify that I have examined: and on my option, he/she is fit to join The Presbyterian University of East Africa.
Name of Physicians: Signature: 
Date: 

Signed by,
Name of Physicians: Signed: Date: 

Official Stamp: 

ACA/ADM/004