



PRESBYTERIAN UNIVERSITY OF EAST AFRICA

MEDICAL EXAMINATION FORM

NAME **ADMISSION. NO.**.....

AGE **SEX**

WEIGHT **HEIGHT**

Skin: - Note: Presence of any

Contagious skin disease e.g. Ring worms

Allergies

Mouth & Teeth: -

Cavities

Occlusion (Normal and maloceluded)

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: Official Stamp: