Hospital Number: .....

BABCOCK UNIVERSITY

ILISHAN-REMO, OGUN STATE
NIGERIA, WEST AFRICA

TBC_____
LAB_____
PE_____
Consent_____
Admissions notified_____

Applicant Medical Report Form

Student or parents fill out this side. The information you provide will help us prepare adequately for health needs.

Name_____
Last *First* *Middle*

Birth date_____
Month *Day* *Year*

Marital status: Single_____ Married_____ Divorced_____ Separated_____ Sex_____

Religion_____ Ethnic background or tribe_____

Home address_____ City_____ State_____

Course of study_____ Department_____

Whom to notify in emergency: Name_____ Phone No: _____ Relationship _____

Address_____

Town_____ State_____

Personal History: Tick (v) to indicate you have any of the medical conditions

	Yes	No		Yes	No		Yes	No
Allergy	___	___	Fatigue/excessive	___	___	Mumps	___	___
Anemia	___	___	Measles	___	___	Nervousness	___	___
Anxiety/tension	___	___	Glandular disorder	___	___	Poliomyelitis	___	___
Arthritis	___	___	Hay Fever	___	___	Scarlet fever	___	___
Asthma	___	___	Headache	___	___	Sleeplessness	___	___
Back trouble	___	___	Heart disease	___	___	Tonsillitis	___	___
Brain concussion	___	___	Hepatitis	___	___	Typhoid	___	___
Cancer	___	___	Hernia/rupture	___	___	Whooping cough	___	___
Chickenpox	___	___	High blood pressure	___	___	Nervous disease	___	___
Colds, frequent	___	___	Influenza	___	___	Pneumonia	___	___
Constipation	___	___	Jaundice	___	___	Rheumonia	___	___
Diabetes	___	___	meningitis	___	___	Sinusitis	___	___
Epilepsy/convulsion	___	___	Mental disease	___	___	Sore throat	___	___
Eczema	___	___	Mononucleosis	___	___	Ulcer	___	___
Fainting	___	___	Others	___	___			
HIV	___	___						

Immunizations History: **Date**

1. Tetanus/Diphtheria toxoid _____
2. Polio _____
3. State others _____

Menstrual History

Painful menses Yes ___ No___
Excessive menstrual flow Yes ___ No___
Duration of flow in days _____
Length of cycle in days _____
Age at menarche _____

Do you take any medicine regularly? Yes____ No_____ If so, state _____

Have you ever had an allergy reaction to serum or drugs? Yes ____ No ___, if yes, please state _____

Do you have any emotional or stress problems for which your wish to see a counsellor? Yes_____ No____ _____

Any physical handicaps? _____ _____ __

Accident or fractures in the past _____ Surgery Yes_____ No_____

The undersigned parent or guardian of the above named student do hereby authorize any officer or member of the faculty of the Babcock University as my agent, in the case of illness or injury to consent to any x-ray examination, anaesthetic, medical or surgical diagnosis or treatment and hospital service which is deemed advisable by and to be tendered under the general or special supervision of a licensed physician: M.D. whether such diagnosis or treatment is rendered at the office of the said physician or at a hospital. Consent is hereby granted by the undersigned to the Babcock University teaching Hospital to release all pertinent medical histories and physical finding to the aforementioned physician. Consent is also hereby granted by the undersigned to the Babcock University teaching Hospital to give immunization for Polio, Smallpox, Tetanus, Diphtheria, Typhoid and Para typhoid to the aforementioned minor.

Date _____ **Student (Minor)** _____

Witness _____ **Father, Mother, OR Guardian** _____

PHYSICAL EXAMINATION

Temperature	_____	Tonsils	_____
Respiratory	_____	Skin	_____
Pulse	_____	Lymphatics	_____
Blood pressure	_____	Thyroid	_____
Height (m)	_____	Heart	_____
Weight (kg)	_____	Lungs	_____
Hip circumference	_____	Breasts	_____
Waist circumference	_____	Abdomen	_____
Hearing	_____	Genito Urinary	_____
Vision	_____	Upper Extremities	_____
Nose	_____	Lower Extremities	_____
Sinuses	_____	Neurological	_____
Mouth	_____	Feet	_____
Teeth	_____	Spine	_____

Laboratory Findings: (note: the following must be within the past year.)

Urinalysis _____ Blood group _____

PCV _____ Genotype _____

Hepatitis C _____ Hepatitis B _____

Pregnancy test _____

HCV _____

1. Do you consider this student physically and emotionally capable of doing university work?
2. Is a normal class load advised? Yes _____ No _____ if No, please give reason:
   _____
3. Is any medical care to be continued while attending school? Yes _____ No _____
4. Is there any reason why this person should not take the regular physical education classes? Yes _____ No _____ if Yes, please give reason _____
5. Remarks (any special health problems or precautions)_____
   _____

Date of this examination: _____

Signature of physician: _____

Name of Physician: _____

Address: _____