

**UNIBEN HEALTH CENTRE MEDICAL EXAMINATION FORM**

**PROVIDE RESPONSE TO THE QUESTIONS BELOW**

**MEDICAL HISTORY**

(i) Are you being treated for any of the following:

Asthma	<input type="checkbox"/>	Sickle cell anaemia	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>
Seizure Disorder	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>
Eye Defect	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>
Mental Health Disorder	<input type="checkbox"/>		

(ii) Are you on any medication; if yes, list them

.....

.....

.....

I certify that the above history is true to the best of my knowledge.

**Date:**.....

.....

**Signature of Student**

**NOTE:** Information given is confidential and it is to enable us provide the required health care.

**To be filled by the physician**

(i) General Examination –

Height (cm):.....	Weight (kg):.....
BMI (kg/m <sup>2</sup> ):.....	Pulse:.....
Blood Pressure:.....	

(ii) Mantoux Test. :.....

If positive, request for Chest X-ray

Chest X-ray Report

Date:..... No..... Results:.....

.....

Place:.....

(iii) Laboratory Investigations

PCV..... Blood Group:..... Genotype:.....

Urine: Glucose ..... Albumin.....Sediments.....

I, Dr. .... certify that after detailed examination,

I find Mr/Mrs/Miss..... to be in Excellent/Good/Fairly good/ Poor health and with/without symptoms of contagious diseases.

Date:.....

**Signature & Stamp of Physician**

**To be filled by the University Medical Officer**

Remarks .....

.....

Date:.....

**Signature & Stamp of Medical Officer**

- NOTE:** 1. MEDICAL CLEARANCE IS A MANDATORY PRE-REQUISITE FOR CLEARANCE AND REGISTRATION  
 2. THE UNIVERSITY WILL NOT TAKE RESPONSIBILITY FOR TREATMENT OF STUDENTS WHO FAIL TO REGISTER WITH THE HEALTH SERVICES DEPARTMENT, SUCH STUDENTS WILL NOT BE ENTITLED TO CREDIT FACILITIES

**STRICTLY CONFIDENTIAL DOCUMENT**