

NAIROBI EVANGELICAL GRADUATE SCHOOL OF THEOLOGY

MEDICAL CERTIFICATE OF HEALTH

(to be completed by examining physician)

Please fill out in block letter.

Name: _____

Male []
Female []

Surname First name Middle name

Date of birth (/ /) Age ___ yrs.

1. Past History: Please indicate with a + and _ and fill in the date of diagnosis.

Tuberculosis []	(/ /)	Renal Disease []	(/ /)
Epilepsy []	(/ /)	Diabetes []	(/ /)
Drug Allergy []	(/ /)	Drug Abuse []	(/ /)
Cardiac Disease []	(/ /)	Psychosis []	(/ /)
Physical impairment []	(/ /)	Hypertension []	(/ /)
Asthma []	(/ /)	Cancer []	(/ /)
Peptic Ulcer Disease []	(/ /)	Rheumatic []	(/ /)
Syphilis []	(/ /)	HIV []	(/ /)
Other communicable diseases []	(/ /)	_____	
Other significant history []	(/ /)	_____	
Regular Medication(s) (state generic name please)			

2. Familiar history of any of the above []

3. Physical Examinations:

Height _____ cms/in. Weight _____ Kgs/lbs
Blood pressure: Systolic _____ mmHg _____ mmHg
Pulse Rate _____ /min [] regular / [] irregular
Eyesight: (R) (L) (R) (L) Colour Blindness

	Uncorrected	corrected
Hearing:	Normal []	Speech: Normal []
	Impaired []	Impaired []

Chest:

- Please describe the result of physical and X-ray examinations of applicant's Chest, also note the exact date of X-ray taken more than 6 months prior to the certification is NOT valid).

Clinical findings: _____

C
E
R
T
I
F
I
C
A
T
E

MEDICAL CERTIFICATE OF HEALTH

X_ ray film
Date (/ /)
Film No. _____
Lung field _____
Cardiomegaly []
Bone Cage _____
Diaphragmatic domes _____

Abdomen: Hernia: [] Liver Enlargement: [] Splenomegaly: []

4. Laboratory Tests:

Urinalysis: pH () glucose () protein ()
Stool: Ova () Cyst () Trophozoities () Occult
Blood ()
Hemoglobin: _____ gm/dl, PCV/HCT _____ %,
WBC count: _____ /cmm
Comment: _____

ESR: _____ mm/Hr, SGOT _____ IU, SGPT _____ IU, y-GT _____ IU

5. Please describe your impression.

6. Conclusion:

In view of the applicant's history and the above findings, is it your observation his /her health status is adequate to pursue rigorous academic and extra_ curricular programs?

/ FIT [] / UNFIT []

Date (/ /) Signature: _____

Physician's Name in print: _____

Address : _____