



Appendix I

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 you 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: _____