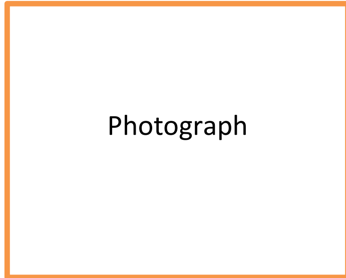
OSUN STATE COLLEGE OF EDUCATION, ILESA

SCHOOL OF ……………………………………………………..

To be completed in Duplicate

From: School Officer,

To: Coordinator, Health Centre,
Health Centre


Photograph

Please note that Candidate Matric No: ……………………………………………………………………………………………

Mr./Mrs./Miss …….
Surname Other Names

whose photograph appears above has been found qualified for admission into Department of ………………………………………………………… Combination ………………………………………………………….. in School of ………………………………………………………… and can now be registered in the Health Centre.

…………………………………………………..
Date

……………………………………………
School Officer
For: The Registrar

OSUN STATE COLLEGE OF EDUCATION, ILESA
HADIJAH OMOLE HEALTH CENTRE

Student Health Bio-Data Form

(To be completed by the Student, Please print)

(a) Surname …………………………………………….. Other Names ………………………………………………………………
Date of Birth …………………………………………… Sex …………………….. Single/Married ……………………….
Telephone No: ……………………………………… E-Mail ………………………………………………..
Nationality ……………………………………………… Ethnic Origin ………………………………………………………..
School: ………………………………………… Dept.: …………………………… Comb …………………………………..
Name, Address, Telephone and E-mail Number of Parent/ Guardian/ Next of kin ………
………
………

(b) Have you ever had or do you now have any of the following: Where yes, please give details.

	YES	NO		YES	NO		YES	NO
Arthritis			G. C.			Migraine		
Asthma			Genio-Urinary Disease			Parasitic/ Worm Disease		
Bone, Joint Disease Other Deformity			Hay Fever			Poliomyelitis		
Bronchitis			Headache (recurrent			Rheumatic Fever		
Eye, Ear, Nose, Throat trouble			High Blood Pressure			Stomach or Duodenal Ulcer		
Dizziness or Fainting			Jaundice			Tuberculosis		
Drug Sensitivity			Kidney Disease			Schistosomiasis		
Dysentry			Liver of Gall Bladder Disease			Others (Specify)		
Epilepsy/ Fits			Malaria					
Filariasis			Menstrual Disorders					

(f) Have you ever received counselling/treatment for emotional disturbances, nervous disorders or mental illness? ……

(g) Give details of any serious illness, injuries and accidents, fractures or operations you have had ………

(h) Give details of any previous admission into hospital as an in-patient for causes other than in (g) above ……

(i) State any current medical/Surgical/Psychiatric treatment you may be receiving ………………………..
………

(j) Has any member of your family or a close relative suffered from Tuberculosis, diabetes, or Mental/Nervous disease? ………………………………………………………………………………………………………

Please give details ……….

(k) Have you been immunized against:

	YES/NO	DATE(S)		YES/NO	DATE(S)
Poliomyelitis Small Pox Tetanus Tuberculosis		Typhoid Yellow fever Others			

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

……………………………………..   ………………………………………………….

DATE   **STUDENT'S NAME & SIGNATURE**

PHYSICAL EXAMINATION BY MEDICAL DOCTOR *CONFIDENTIAL*

PART II (To be completed by a Doctor at The Health Centre or Recognized Government Hospital)

(a) Height ……………………………………… Weight ……………………………….

Nutritional State: Thin/Average/Obess

(b) (i) Distant Vision (Snellens or similar Test-Type) (ii) Colour vision:

Without Glasses R. 6/ L. 6/ Normal/Abnormal

Corrected/with Glasses: R. 6/ L. 6/

(c) Hearing: Right ear (d) Pulse (Rate etc)

Left ear Blood Pressure: Systolic ……. Diastolic …..

(e) Clinical examination: Describe any important abnormality, please

		Normal	Abnormal
Head and Neck			
Conjuctivate & Mucous Membranes			
Tongue			
Teeth & Throat			
Ear, Nose and Simuses			
Lymph Glands			
Chest and Lungs			
Heart			
Abdomen			
Haemorrhoids or Fistula			
Genito-Urinary (Including Hernial Orifices)			
Nervous System	Pupilary reflexes Spinal reflexes		
	Protein		
Urine	Sugar		
	Others		

(f) Stool Examination Parasites: ……………………………………………………………

Occult Blood: …………………………………………………………………………….

(g) Blood Hb% ……………………………… P.C.V. ……………………………………

W. B. C. & Differential ……………………………………………………………

(h) Place, Date, Number and Report of Chest X-ray (The X-ray picture must be taken at Government Recognized Hospital ……………………………………………………….

(i) Summary of Significant abnormalities ………………………………………………

………………………………………………………………………………………………

………………………………………………………………………………………………

(j) Assessment: I have today examine Mr./Mrs./Miss ………………………………………

……………………………………………………………………………………… and he/she **is / is not**, in my opinion, free from physical defect, organic or nervous ailment or their after-effects likely to impair or disturb mental and physical activity in a University. He is free/not free from infectious diseases.

I assess his health and physical condition as Excellent/Good/Fair/Poor

(k) She is/is not pregnant.

Date …………………………………….. Signature of the Physician ……………………

Name: ………………………………………

Address: ……………………………………

(Affix Hospital Official Stamp)

……………………………………………………………………………………………………

PART III (To be completed by the College Medical Officer)

Remarks: …………………………………………………………

Date: ……………………………………………………………….

…………………………………………

Name & Signature