ADM No.:

KENYA INSTITUTE OF MASS COMMUNICATION
P.O. Box 42422 - 00100 NAIROBI | Uholo Road, Nairobi South B, off Mombasa Road
Cell: 0708 262 895 Tel: +254 020 6997000 | Email: info@kimc.ac.ke | Website: www.kimc.ac.ke

MEDICAL REPORT

It is a prerequisite by the Institute that all the students joining the Institute must complete and bring with them a duly completed medical form during registration. Please print and fill this form.

Part I *(to be filled by the student)*

Student Name: …… …… ……

Surname First Name Middle Name

Tel No…… County: …… Date of Birth: …… Gender: ……

Course Enrolled: ……..

Training Department: …… Nationality: ……

Mode of Study: Day [ ] Evening [ ] Residence Status: Boarder [ ] Day scholar [ ]

Please indicate the Name of the High School/College/University were you in:

……..

Next of Kin

Name of Father: …….... Tel. No.: ……...

Name of Mother: …….... Tel. No.: ……...

Name of Guardian: …….... Tel. No.: ……...

Part II: *(To be completed by the parent/guardian, in consultation with a medical doctor)*

NB: The information will help the Institute to provide emergency services when needed

Have you ever been admitted to a hospital? Yes [ ] No [ ]

If so, when and for what illness/operation?

……

Are you a Person with Disability (PWD)? Yes, [ ] No [ ] NCPWD Registration Number: ……....

Please describe the form of disability: ……

Have you ever suffered from any of the following? Yes [ ] No [ ] *(Please tick where appropriate).*

Conditions/Ailments	Yes	No
Allergies		
Peptic Ulcer Disease		
Heart Disease/ Chest Pain		
Surgeries/ Back Problems		
Asthma/Epilepsy/Diabetes (Tick any)		
Mental Illness		
Severe Headaches		
High Blood Pressure/ Low Blood Pressure		
Hepatitis/Jaundice		
Kidney Diseases		
Tuberculosis/ Persistent cough for more than two weeks		
Anemia/Unexplained Syncope/blood related diseases		
Hearing Problems		
Eyesight problems		
Currently on any Drugs for treatment of a medical condition? Give name and dose		
Give any other medical concern(s) that you may feel relevant		

Is there anyone in your family who have an existing medical condition? Yes [ ] No. [ ]

If yes, please explain: ……

Part III: Vaccination Status

Vaccines (Please print the certificate/Card where applicable)	Yes	No
All KEPI Vaccines		
Covid -19 Vaccines		
Hepatitis Vaccine		
Yellow Fever Vaccine		

Part III *(To be filled by a Doctor in Government Hospital)*

General Medical Condition

Temp: …… BP: …… P/HR: …… RBS: ……

Blood Group: …… Height: …… Weight: …… BMI: ……

Respiratory System:

Clinical Findings: …… Respiratory Rate: ……

Percussions: …… Auscultation: ……

Alimentary System

Teeth: …… Tongue: …… Abdomen: …….

GENITO-URINARY SYSTEM

Urethra Discharge: ……. L.M.P: …… Uterus: ……

Urine: ……. S.G: …… Albumin: …… Sugar: ……

Deposit: …….

DECLARATION:

I hereby certify that I have today examined the above-named person and, in my opinion, declare that he/she is medically CAPABLE/NOT CAPABLE of undergoing a practical and theoretical training in Institute.

Name of Medical Officer ……..

Mobile: …… Medical Practitioners and Dentist Board Reg. No ……

Signature …… Date: ……

Official rubber stamp…….

Part IV *(To be filled by Student/ Guardian/Parent)*

NHIF Card No./ Any Other Valid Medical Insurance Card	
Principal Contributor Id	
Principal Contributor Tel. No.	
Hospital Of Choice/ Accredited Hospital	
Any Other Comment	

Important Note

Any student seeking medical services at the KIMC clinic must identify himself/herself using the student's Identification Card. Such services shall be provided only when the student is in session. Parents /guardians are encouraged to secure NHIF or any other medical cover for the children.

Declaration

I …… Parent/Guardian confirm that the above statement is correct. In the event of any emergency cases, I authorize the Institution to take the student to the hospital of choice or any Public Health Facility.

Signature: ……. Date: ……

Part V: Official ***(To be filled by the Person in-charge of Clinic)***

Comments by the Institute Medical Officer

Remarks…….

……..

Does the student require any special medical needs? Yes [ ] No [ ]

Please, give details: ……

Name: ……. Signature: …….

Date & Stamp: …….