ARUSHA ADVENTIST COLLEGE MEDICAL EXAMINATION FORM

I.Personal Information

- **Full Name:** _____
- **Date of Birth:** _____
- **Gender:** ☐ Male ☐ Female
- **Student ID (if available):** _____
- **Program of Study:** _____
- **Contact Information:**
  - Phone: _____
  - Email: _____
- **Emergency Contact Person:**
  - Name: _____
  - Relationship: _____
  - Phone: _____

II.Medical History

1. **Do you have any known chronic illnesses?**
   ☐ Yes ☐ No
   - If yes, please specify: _____
2. **Are you currently on any medication?**
   ☐ Yes ☐ No
   - If yes, please list the medications: _____
3. **Do you have any allergies?**
   ☐ Yes ☐ No
   - If yes, please specify: _____
4. **Have you had any surgeries or hospitalizations in the past?**
   ☐ Yes ☐ No
   - If yes, please provide details: _____
5. **Have you been diagnosed with any psychological conditions (e.g., anxiety, depression)?**
   ☐ Yes ☐ No
   - If yes, please specify: _____
6. **Do you have any physical disabilities or limitations?**
   ☐ Yes ☐ No
   - If yes, please specify: _____

III.Physical Examination

Category	Normal	Abnormal	Remarks
Height	☐	☐	_____
Weight	☐	☐	_____
Blood Pressure	☐	☐	_____
Heart Rate	☐	☐	_____
Vision (with/without glasses)	☐	☐	_____
Hearing	☐	☐	_____
Respiratory System	☐	☐	_____
Cardiovascular System	☐	☐	_____
Musculoskeletal System	☐	☐	_____
Abdomen	☐	☐	_____
Skin	☐	☐	_____

IV.Laboratory Tests

- **Blood Test:** ☐ Required ☐ Not Required
- **Urinalysis:** ☐ Required ☐ Not Required
- **Other Tests (specify):** _____

V.Vaccination History

- **Tetanus:** ☐ Yes ☐ No
- **Hepatitis B:** ☐ Yes ☐ No
- **Measles, Mumps, Rubella (MMR):** ☐ Yes ☐ No
- **COVID-19:** ☐ Yes ☐ No
- **Other (specify):** _____

VI.Doctor's Assessment

- **Overall Fitness Status:**
  ☐ Fit for college studies
  ☐ Fit with limitations (specify): _____
  ☐ Not fit for college studies (specify): _____

VII.Doctor's/Medical Practitioner Signature and Stamp

- **Doctor's Name:** _____
- **Signature:** _____
- **Date:** _____