



FORM C: MEDICAL EXAMINATION

The Deputy Vice Chancellor Academic Affairs
Ardhi University
P.O. Box 35176
DAR ES SALAAM

SURNAME:..... AGE: SEX:.....
FIRST NAME
OTHERNAME:.....
SCHOOL:..... DEGREE PROGRAMME:.....
MARITAL STATUS:.....

A: PERSONAL HISTORY *(To be completed by the applicant)*

1. Have you ever suffered from any serious diseases or disorders? **(YES* / NO*)**
If YES, explain
.....
.....
.....
2. Are you suffering from or having any medical conditions/disabilities/disorders that require necessary attention? **(YES* / NO*)**
If YES, explain
.....
.....
.....

I declare that the information provided above is correct.

Date Signature:.....

B: PHYSICAL EXAMINATION (To be completed by registered medical practitioner)

1. General Examination

Weight..... height Blood Pressure Pulse rate.....
SPO2.....

2. Systemic Examination

- i) Central Nervous System (CNS).....
- ii) Respiratory System (**Attach evidence e.g., Chest x-ray for Tuberculosis**)
.....
- iii) Cardiovascular System (CVS).....
- iv) Gastrointestinal System (GIS).....
- v) Genital Urinary System (GUS).....
- vi) Gynecological System
- vii) Musculoskeletal System (MSS).....
- viii) Others if any (Specify).....

3. Investigations, (Please Specify if Necessary and Attach Results)

- i)
- ii)
- iii)

C: CONCLUSION

I have examined **Mr./Miss / Mrs**
and consider that **he*/she*** is physically and mentally **fit*/not fit*** to be admitted to the
University for higher studies.

Name of the examining Medical Practitioner

Title:

Qualification

Signature:..... Date

Official Stamp:

****Delete whichever inapplicable***