INTERNATIONAL LEADERSHIP UNIVERSITY
DEVELOPING LEADERS OF INTEGRITY

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CERTIFICATE OF HEALTH

This form is to be completed and returned by the medical officer examining the applicant.

PART I (To be completed by the applicant)

Name _____ Date of birth ___/ ___/___

Address _____ Sex: [ ] Female [ ] Male

In case of emergency, the following person(s) should be notified:

Name _____ Relationship to applicant _____

Telephone (office) _____ (Home) _____

Address_____ (code)_____

MEDICAL HISTORY

Have you ever been admitted into hospital? Yes [ ] No [ ]

If yes, state reason for admission and date _____

_____

Do you suffer from any physical disability? Yes [ ] No [ ]

If yes, please explain _____

Do you require any special diet? Yes [ ] No [ ]

If yes, specify? _____

Do you have a medical insurance cover? Yes [ ] No [ ]

If yes, stay terms of the cover: Inpatient [ ] Outpatient [ ] Both [ ]
Duration of cover_____

Name of insurer? _____

Are there any other relevant details of your medical history not covered by this page? Please give particulars. _____

Applicant's signature _____ Date _____

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PART II (To be completed by examining medical Officer)

a. Height _____ Weight _____

b. Visual acuity

Without glasses R.6/ L.6/

With glasses R.6/ L.6/

c. Hearing Right ear _____ Left ear _____

d. Condition of:

Teeth _____

Nose _____

Throat _____

e. Lymphatic glands _____

Circulatory system _____

Pulse _____

Blood Pressure _____

Respiratory system _____

f. Abdomen _____

Spleen _____

Any evidence Of hernia _____

g. Any other observation of importance (e.g. physical or mental disabilities) _____

_____

_____

Signature of physician _____ Stamp

Address and qualifications _____

_____