AFRICA INLAND CHURCH

RAVINE BIBLE COLLEGE

P.O. Box 9 – 20103, Eldama Ravine, Kenya

"And the things you have heard me say in the presence of many witnesses entrust to reliable men who will also be qualified to teach others." 2 Timothy 2:2

CERTIFICATE OF HEALTH

(To be completed by the examining Medical Officer).

Part I

Name ……..…… Date of birth …….……. Sex ….....….

Address ……..……...……..…….

Name and address of Parent/Guardian/Wife/Husband or next-of-kin to be notified in case of emergency:

Name …….. Relationship ……..…….…….

Address ……. Phone No....…...……

Has the person ever been admitted into hospital: Yes/No (Circle one)

If yes, state reason for admission and date …….
……...……..……

Has the patient ever had any of the following illnesses? (Circle one)

a.	**Tuberculosis or other chest infection**	**Yes/No**
b.	**Fits, nervous disease or fainting attacks**	**Yes/No**
c.	**Heart disease or rheumatic fever**	**Yes/No**
d.	**Any disease of genital-urinary system**	**Yes/No**
e.	**Asthma**	**Yes/No**
f.	**Diabetes**	**Yes/No**
g.	**Sexually transmitted disease**	**Yes/No**
h.	**Any disease of the digestive system**	**Yes/No**
I.	**Epilepsy or Seizures**	**Yes/No**
J.	**Malaria**	**Yes/No**
k.	**Typhoid**	**Yes/No**
l.	**Allergies to food or drugs (please specify)**	**Yes/No**

If the answer to any of the above is yes, please give details with date:

……...……

……..……..……

Does this person suffer from any physical disability? Yes/No (Circle one)
If yes, please explain:

……..……

If there are any other relevant details of the medical history not covered by this page, please give particulars. ……..……

Has any member of the family suffered from: (Circle the answer)

a.	**Tuberculosis**	**Yes/No**
b.	**Insanity or mental illness**	**Yes/No**
c.	**Diabetes**	**Yes/No**

Does the patient require any special diet? Yes/No (Circle one)

If yes, specify……..……..

……..……

<u>Part 2</u>

Height: ……..……..…….. Weight: …….

Visual acuity

Without glasses R…….……. L……...…..……..
With glasses R…….. L……...……

Any visual problems:

Glasses Needed? ……..…. Nearsighted? …….…. Farsighted? ……..….

Comments:…….…….…….

Hearing Right ear……. Left ear……..……..

Condition of:

Teeth ……

Nose ……

Throat ……..

Lymphatic gland: …….…….

Circulatory system: ……

Pulse: …….…….…….…….

Blood Pressure: ……...…….…….

Respiratory system: ……..…… ……..……

Abdomen: ……...……..

Spleen : ……..……

Any evidence of hernia: …….……

Any medications the patient is presently taking? ……..……...

Any other observation of importance (e.g. Physical or mental disabilities)? …….……..

……..……..……...

<u>Result of HIV test – COMPULSARY (Results of this test MUST be attached)</u>: ……..……..

Date: ……..…… (Official Stamp)

Signature of Medical Officer: ……

Address and qualifications: ……..

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