ADMISSION TO THE KEST PROGRAMME
MEDICAL FORM
(SF 105)

Surname	
Other Names	
Gender	
Date of Birth	

Have you ever been in hospital?	Yes/No
If "yes", state reasons for admission and date	

Have you ever had any of the following illnesses? (Please tick)

❑ Allergies to food or drugs	❑ Fits, nervous disease or fainting attacks
❑ Any disease of the digestive system	❑ Heart disease or rheumatic fever
❑ Any disease of the genito-urinary system	❑ Sexually transmitted diseases
❑ Epilepsy	❑ Tuberculosis or any other chest infection

If you ticked any of these boxes, please give details and dates

Do you require a special diet?	Yes/No
If "yes", please give details	

Do you suffer from a physical disability?	Yes/No
If "yes", please give details	

Has any member of your family suffered from any of the following? (Please tick)

❑ Tuberculosis	❑ Insanity or mental illness	❑ Diabetes

Please give any other relevant details of your medical history that have not been covered

I confirm that to the best of my knowledge the information overleaf is true and complete and that I am not deliberately omitting any relevant information.

Student Signature		Date	

MEDICAL INSPECTION REPORT

(Communicable Diseases, Audio, Visual)

This section is to be completed by a fully qualified Medical Doctor ONLY:

I hereby certify that I have completed a medical examination of: ____________________________
(Name of Patient)

this _______ day of ____________ in the year 200__ and found him/her to:

OR	❑ Be free of any infectious communicable diseases; ❑ Be diagnosed as having an infectious communicable disease, and should not participate in a closed group activity such as classroom until prescribed medicine has rendered the person as being non-infectious.
	❑ Have an eyesight problem that requires prescription lenses to see visual teaching aids clearly.
	❑ Have a hearing impairment which will/may affect his/her in absorbing verbal teaching presentations.

Any other comments:

I confirm that, to the best of my knowledge the information given about this patient is true and complete.

Doctor's Full Name:		**Date**	
Medical Facility/ Practice & Official Stamp:			
Doctor's signature:			