EDE PREMIER INSTITUTE

...setting the standard in academic and moral excellence

Health Services
Physical Add: EPI Mini Campus, Ara-Ejigbo Junction
Iwo-Osogbo Road, Ede, Osun State
Postal Add: P. O. Box 104, Ede, Nigeria
Tel: +234(0)8038584757; +234(0)8038063582
email: epinstitute.edu@gmail.com

MEDICAL CLEARANCE FORM

Name of Candidate: ……………………………………………………………………………………………….

Date of Birth: ……………………………………………. Sex: ………………………………………

Nationality: …………………………………………….. Age ……………………………………....

Name of parent or Guardian: ……………………………………………………………………………

Address: …………………………………………………………………………………………………
……

Past illness: Give date of same if positive 'YES' and Negative 'NO'

Childhood disease

- Measles: ……………… Malaria: ………………
- Mumps: ……………… Dysentery: ……………
- Whooping Cough:…….. Epilepsy: ……………..
- Chicken pox: ………….. Rheumatic fever: ………..
- Diphtheria: ……………. Allergies: ………………..
- Scarlet: ……………….. Any others: ………………

Family History

- Allergies: …………………… Antimalaria drugs taken: ………………………..
- Insanity: ……………………. Other medication taken regularly ………………
- Diabetes: …………………… ……………………………………………
- Tuberculosis: ……………….

Hospitalization

- Date and reason: ……………………………………………………………………………
- Other serious illness: ………………………………………………………………………
- Name of parents: ……………………………………………………………………………
  Signature: …………………………………………… Date: ……………………………

PHYSICAL EXAMINATION

- Height: …………………………… Ear:…………………………………….
- Weight: ………………………….. Mouth: ……………………………..
- Eyes:…………………………….. Throat: ……………………………..

- Nose: ………………………….. Teeth: ……………………………..
- Chest: ………………………… Scalp: ……………………………….
- Heart: ………………………….. Rate: ……………………………..
- Lungs: ………………………… Blood Pressure reading: …………
- Chest x-ray No: ………………. Date: …………………………….
- Radiologist comment: ……………………………………………………………………………
  ……………………………………………………………………………….…

LABORATORY EXAMINATION

Urine analysis

- pH:………………………… Albumin: ………………………..
- Sugar: ……………………… Others: (i) ……………………..
  (ii) ……………………..

Blood Analysis

- PCV ……………………. TLC ………………………….
- Neutrophil count………………………… Monocyte…………………….
- Lymphocyte……………………………. Blood Group:…………………
- Ecsinophil……………………………… Hb Genotype: ………………..
- Basophil……………………………….

CERTIFICATION

I consider ………………………………………………………………. capable/not capable of taking part in all school activities without danger to himself / herself or others. (Please, elaborate here if you wish to make any modification in the above statement or recommended treatment) …………………………………………......
……

Name and Signature of Examining Medical Doctor: …………………………………………………………

Signature and official stamp of HOU, Health Services: ……………………………………………………..

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