

**UNIVERSITY OF ILORIN
ACADEMIC OFFICE**

UNILORIN HEALTH SERVICES REGISTRATION CERTIFICATE

This is to certify that the bearer, Mr/Mrs/Miss.....

.....of.....Department

Level.....Faculty.....Sex.....

State of Origin.....Nationality.....

Matric No.....has completed his/her Registration with the University

Health Services.

Clinic Registration No.

Signature of StudentDate

Signature of the Director of Health Services Date

STUDENTS INFORMATION FORM (SIF)



1. REGISTRATION NUMBER ----- LEVEL _____

2. NAME (Prof/Dr/Mr/Mrs/Miss) -----
 TITLE SURNAME FIRST-NAME MIDDLE NAME

 FORMER SURNAME IF ANY

3. SEX M/F 4. DATE OF BIRTH DAY MONTH YEAR 5. NATIONALITY CODE

6. PLACE OF BIRTH _____
 TOWN/VILLAGE STATE

7. PLACE OF ORIGIN _____
 TOWN/VILLAGE STATE L.G.A. CODE

8. MARITAL STATUS (ENTER APPROPRIATE LETTER) (S - SINGLE (M - MARRIED) D- DIVORCED) W-WIDOW)

9. RELIGION (ENTER APPROPRIATE LETTERS) (C - CHRISTIANITY (ISLAM) T - TRADITIONAL) O - OTHERS)

10. ADDRESS

(A) PERMANENT/HOME ADDRESS _____

 (B) CONTACT ADDRESS _____

11. NEXT OF KIN NAME _____
 ADDRESS _____
 RELATIONSHIP _____
 TELEPHONE _____

12. SPONSOR NAME _____
 ADDRESS _____

13A. MODE OF ENTRY (TICK ONE) FOR UNDERGRADS ONLY (ENTER APPROPRIATE LETTER) (C-CONCESSIONA, R - REMEIDAL). (J-JME D -DIRECT, T -TRANSFER, M - MATURE)

13B. IF TRANSFER, PREVIOUS UNIVERSITY _____

13C. PROGRAMME TYPE S-SUB DEGREE, F - FIRST DEGREEM, P - POST DIP/CRT, H - MASTER/Ph.D.

14. HIGHEST QUALIFICATION (ENTER APPROPRIATE NUMBER) 1. SSCE 2.WASC/GCE OL. 3 TCH/AGE 4. HSC/GCE AL, 5. ND. 6. HND. 7. NCE 8. BACHELOR'S DEGREE 9. PGD 10. MASTERS 11. Ph.D 12. OTHERS PLEASE SPECIFY _____

15. QUALIFICATION WITH DATES:

A. SSCE/GCE/OL (With Grades) (B) GCE/AL/IJMB (With Grades)

15B. INSTITUTION WHERE OBTAINED: _____ DATE _____

16. SUBJECT OF FIRST DEGREE _____
(FOR POSTGRADUATE ONLY)

17. YEAR OF ENTRY INTO PRESENT INSTITUTION _____

18. AWARD IN VIEW _____

19. COLLEGE _____

CODE

20. FACULTY/SCHOOL _____

21. DEPARTMENT/INSTITUTE _____

CODE

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22. MODE OF STUDY
(ENTER APPROPRIATE LETTER)

(F- FULL TIME P-PART TIME (DAY)
(W- WEEKEND E-EVENING)
(S- SANDWICH/LONG VACATION
(O-OCCASIONAL X-EXCHANGE)
(C-CORRESPONDENCE)

23. NORMAL COURSE DURATION _____

24. EXTRACURRICULAR ACTIVITIES _____

25. HEALTH STATUS

NORMAL

DISABLED

26. IF DISABLED, STATE _____

IF SPECIAL MEDICATION IS REQUIRED STATE TYPE _____

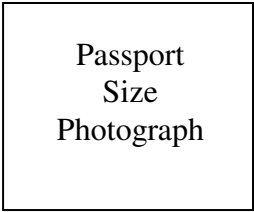
SIGNATURE OF STUDENT

DATE

UNIVERSITY OF ILORIN

STUDENT ENTRANCE MEDICAL EXAMINATIONS

Undergraduate And Postgraduate students are requested to complete Part of this form, Part II should be completed with the help of the University Medical Doctor. The form should be returned to the Director, University Health Services after completion. The information will be treated in strict confidence.



PART 1 (to be filled in by the student)

Surname: Other Names:

Age next Birthday:..... Sex:..... Married or Single.....

Nationality: State of Origin.....

L.G. A.:.....

Faculty:.....

(a) Would you say your health was good/fair/poor:.....

(b) Have you ever been admitted as an in-patient into a hospital ?.....
If so please state reason for admission, name of Hospital and date

.....

(c) Do you suffer from or have you suffered from any of the following:

Tuberculosis : YES/NO

Passing blood in the urine .../ Yes/No

Any disease of the heart Yes/No

Any respiratory disease/ Yes/No

Any general disease of the Kidneys/bladder Yes/No

Any disease of ear, nose and throat /Yes/No

Allergies e.g. asthma Yes/No

Any disease of the digestive
e.g Peptic ulcer, hernia,
piles etc. Yes/No

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

.....

.....

.....

.....

(d) If there are any other relevant details of your Medical history not covered by the above questions, please give particulars:.....

(e) Is your family a healthy one?.....Has any of your family suffered from Tuberculosis, insanity or mental disease?

(f) Have you been immunized against any of the following:

Small Pox Yes/No:.....

Tetanus Yes/No:

Others Yes/No:.....

Date.....Student:

Signature

PART II (To be completed by the University Medical Doctor)

Visual acuity:

Without Glasses R 6/ L. 66/ x Snellon Types
With Glasses R 6/

Hearing

Left
Right

Circulatory System

Heart
Blood Pressure

Respiratory System

Eyes
Ears
Pharynx
Teeth
Lymphatic Glands
Skin
C.N.S.
Pupillary Reflexes
Spinal Reflexes
Chest X.Ray

Lungs
Abdomen
Liver
Spleen
Hernia
Urine
Alb
Sugar

Film No.....Hospital.....Attach Radiologist Report

ANY OTHER OBSERVATIONS:

Remarks.....

Date.....

Medical Officer

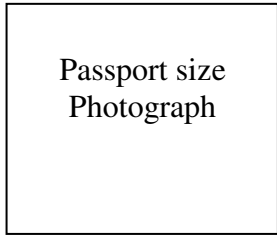
Address.....

.....

.....

UNIVERSITY OF ILORIN
STUDENT AFFAIRS UNIT

STUDENT PERSONAL DATA



Passport No:.....

Date Issued:.....

Where Issued:

Passport Valid till:.....

Visa/Residence Permit Valid till:

(PLEASE COMPLETE LEGIBLY IN BLOCK LETTERS
AND RETURN TO STUDENT AFFAIRS DIVISION)

1. Surname:.....
2. Other Names:.....
3. Date of Birth
4. Place of Birth: (Home Town):
5. State of Origin:
6. Nationality:.....
7. Permanent Home Address:.....
8. Vacation Address:.....
9. Name and Address of Guardian in Ilorin:
10. Sponsor (Full Name and Address):
-Telephone.....
11. University (ties) previously Attended:
12. Year and Reasons for Leaving:
13. Any Special and Continuous Medical Treatment Being Received and where:.....
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14. Marital Status:.....No. of Children.....
15. Precious NYSC Service: Yes/No
16. Service Year:.....Discharge Certificate No.:.....
17. Hall of Residence and Room No.:
18. When Expected to go Off Campus:.....
19. Off Campus Address:.....
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- Faculty:.....
- Department:.....
- Present Year of Study:
- Full Time Part -Time Occasional
20. Subject Combination:.....
21. Year of Entry and Matriculation No:.....
22. Year of Graduation:.....

INFORMATION ON PARENTS

1. Father's Full Name and Contact Address:.....
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2. Mother's Full Name and Contact Address:.....
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