# GHANA NATIONAL COLLEGE
## CAPE COAST

P. O. BOX 161
CAPE COAST
Tel.: 0332096346
E-Mail: ghananationalshs@ges.gov.gh
GPS: CC-044-6515

**BANKERS:**
GCB BANK


## MEDICAL EXAMINATION FORM

*(To be completed with the assistance of a Medical Doctor)*

1. Name of Student: .....
2. Date of Birth: .....
3. Weight Now: .....
4. Height Now: .....
5. Does Student suffer from:
    a) Sickle-cell disease: .....
    b) Rheumatism: .....
    c) Asthma .....
    d) Fainting spells: .....
    e) Epilepsy: .....
    f) Mental disease: .....
    g) Bedwetting: .....
    h) Any other condition, which may need special attention:
    .....
6. Has student had any serious illness or operation at any time in his/her life?
    .....
    a) If yes, when? .....
    b) Name of Doctor: .....
    c) Name of Hospital: .....
7. Does the student have any eye impairment? If yes, describe.

    .....

    .....
8. Has student had his/her teeth checked by the dentist recently? .....

9. Can student take part in all normal physical activities like sports, games house cleaning etc.: .....

10. Does student have to take any regular medical check-up(s)? If so, on what, how often and why?
.....

.....

11. What medicines are you allowing the student to bring to school?

.....

12. Any other comment or information you would like us to know.
.....
.....
.....

13. Laboratory report on:
    a) Chest .....
    b) Eyes .....
    c) Urine (STD), etc .....
    d) Sickling/blood group .....

14. Is student allergic to any food? .....
If yes, please attach a medical certificate to explain. (**NB**: Corn, Kontomire, and Beans are basic foods in the School's menu).

**NB:** *Failure to disclose medical information about the student absolves the school from any liability arising thereof.*

## DECLARATION OF MEDICAL FITNESS

(Please use BLOCK LETTERS only)

**Name of Doctor (Surname, Other names):**

_____

**Hereby state that**
**Mr./Ms. (Surname, Other names):**

_____

**Born (City, Country):** _____

**On (dd/mm/yyyy):** ___/___/_____

**And resident at (address, city, country):**

_____
_____
_____

According to the results of medical check-up and examinations, is currently **healthy and fit/unhealthy and unfit** for his/her Senior High School education.
If unhealthy and unfit, recommendation.

_____
_____
_____
_____

**Date: (dd/mm/yyyy)**

____/____/_____

**Doctor's signature and stamp:**

**Tel.:** .....

**Email:** .....

**NB:** *The medical report would be accepted only from a recognized and registered health facility.*