

Masinde Muliro University of Science and Technology

Tel: 0702-597360/1 EXT 2101
E-mail: registraraa@mmust.ac.ke
Website www.mmust.ac.ke



P.O Box 190
Kakamega
50100
Kenya

Office of the Dean of Students

BOND

I,.....Registration Number.....
(FULL NAME)

I hereby bond myself to be of good conduct during my stay at the Masinde Muliro University of Science and Technology.

I also bond myself to abide by all the University Rules and Regulations as contained in the Student Guide.

Failure to adhere to the above, the Masinde Muliro University of Science and Technology will reserve the right to institute disciplinary procedures against me.

Signed:.....Date:.....

Signed:
(Dean of Students)

Rubber Stamp.....

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P.O Box 190
 Kakamega
 50100
 Kenya

Games and Sports Department MMU/2B

PERSONAL INFORMATION ON SPORTING AND GAMES ACTIVITIES

Name:.....

Reg No.:..... Campus:.....

Tel. No.:..... Email No:.....

Indicate by a tick (✓) the game/sport you have participated in or of your interest

NO.	GAME	LEVEL OF PARTICIPATION					Sport/Game of Interest
		Zonal	County	Regional	National	International	
1	Soccer						
2	Netball						
3	Volleyball						
4	Handball						
5	Rugby						
6	Athletics-track/field						
7	Basketball						
8	Chess, Scrabble, darts						
9	Tennis						
10	Martial arts						
11	Swimming						
12	Hockey						
13	Badminton						
14	Table tennis						
OTHERS							
1							
2							
3							
4							

Signed..... Date.....

(b) Full Name of Mother: _____
 (SURNAME) (FIRST NAME) (INITIAL/OTHER)

Deceased Alive Occupation _____
 Date of Birth Day Month Year

10. (a) Full Name of Guardian _____
 (SURNAME) (FIRST NAME) (INITIAL/OTHER)

(b). Occupation of Guardian _____
 I/D No.

11. Address of Parent/Guardian _____
 P.O. BOX CITY/TOWN

TELEPHONE (LANDLINE) MOBILE PHONE E-MAIL ADDRESS

12.(a) Name of Next of Kin _____
 (SURNAME) (FIRST NAME) (INITIAL/OTHER)

(b) Address of Next of Kin _____
 P.O. BOX CITY/TOWN

I.D. NO.

TELEPHONE (LANDLINE) MOBILE PHONE E-MAIL ADDRESS

13. Place of Birth: Village _____

Location _____ Name of Chief _____

Division _____ County _____ Constituency _____

14. Place of Permanent Residence:

Village _____ Nearest Town _____ Nearest Police Station _____

Location _____ Name of Assistant Chief _____ Name of Chief _____

15. Give names and addresses of two persons who can be contacted in case of emergency.

(i) _____
 (SURNAME) (FIRST NAME) (INITIAL/OTHER)

RELATIONSHIP P.O. BOX TOWN/CITY

TELEPHONE (LANDLINE) MOBILE PHONE E-MAIL ADDRESS

(ii) _____
 (SURNAME) (FIRST NAME) (INITIAL/OTHER)

RELATIONSHIP P.O. BOX TOWN/CITY

TELEPHONE (LANDLINE) MOBILE PHONE E-MAIL ADDRESS

16. Name and address of Secondary School attended:

	NAME	ADDRESS	TOWN	DATES	
				FROM	TO
1.					
2.					

17. KCE/KCSE or equivalent Results (Subjects & Grades)

Mean Score/Division (where applicable)

18. Name and address of School attended for KCSE/"A" Level (Where applicable)

(a) Name _____

(b) Address _____

P.O. BOX

TOWN/CITY

19. KCSE Results/"A" Level Results (Subject and Grades)

20. Any other Institutions attended and Qualifications attained

	NAME	SPECIALIZATION	QUALIFICATIONS
1.			
2.			

21. Games/Sports: Which games and Sports do you participate in:

01. Soccer 02. Hockey 03. Basketball 04. Netball

05. Tennis 06. Badminton 07. Rugby 08. Volleyball

09. Athletics 10. Swimming 11. Table Tennis 12. Darts

13. Karate 14. Martial Arts 15. Others

If you represented your school, etc. in games please give details:

22. Clubs and Societies: Which clubs and societies are you interested in:

Please give details of your application.

(a) First Choice _____
(b) Second Choice _____

23. Do you suffer from any physical/health impairment? If so give details.

No. Yes

Please state the condition

24. Please give any information you think is useful for you to communicate to the University.

I certify that the information I have provided is correct.

Signature: _____ Date: _____



MMU/4

AFFIX
COLOURED
PASSPORT
SIZE PHOTO
HERE

Office of the Registrar (Academic Affairs)

Masinde Muliro University of Science and Technology

ENTRANCE MEDICAL EXAMINATION Form

IMPORTANT

Students are requested to complete Part 1 of this Form. Part 11 should be filled by a Certified Medical Practitioner at a Government Hospital. The completed Form should be brought personally and presented to the Medical Registration Officers on the day of Registration by the student. No medical reports should be brought earlier or sent by post.

PART 1

- (a) SurnameOther Names
Date and place of birthSexNationality.....Race.....
Religion..... Marital Status.....
Faculty/School/Centre.....Registration Number.....
Name, Address, and Telephone Number of Parent/Guardian/Next of
- (b) Have you ever been admitted in a hospital?
If so, state reason for admission and date.....
- (c) Have you had any of the following illness:
(i) Tuberculosis or other chest infection?Yes/No
(ii) Fits, Nervous disease or fainting attacks?.....Yes/No
(iii) Heart disease or Rheumatic fever?Yes/No
(iv) Any disease of the digestive system?Yes/No
(v) Any disease of Genito Urinary System?Yes/No
(vi) Allergies to food or drugsYes/No
(vii) Malaria?.....Yes/No
(viii) Sexually Transmitted Disease?Yes/No
(ix) Poliomyelitis?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) Has any member of your family suffered from:
(i) Tuberculosis?Yes/No
(ii) Insanity or Mental illness?Yes/No
(iii) Diabetes Mellitus?Yes/No
(iv) Heart disease?Yes/No
- (f) Have you been immunized against any of the following diseases:
(i) Measles? Yes/No Date.....
(ii) Tetanus? Yes/No Date.....
(iii) Poliomyelitis? Yes/No Date.....
(iv) Tuberculosis? Yes/No Date.....
(v) Typhoid? Yes/No Date.....
(vi) Hepatitis B? Yes/No..... Date.....
(vi) Yellow fever? Yes/No..... Date.....

Signature of Student: _____ Date: _____

PART 11

(To be completed by the Examining Medical Officer)

- (a) Height.....Weight.....
- (b) Visual Acuity:
 - Without glasses R.6/..... L./6.....
 - With glasses R.6/..... L./6.....
- (c) Hearing: Right Ear..... Left Ear.....
- (d) Condition of:
 - Teeth:
 - Nose:
 - Throat:
- (e) Lymphatic glands.....
- Circulatory System.....
- Pulse.....
- Blood Pressure.....Systolic.....Diastolic.....
- (f) Respiratory System.....
- (g) Abdomen.....
- Spleen.....
- Any evidence of Hernia.....
- Any evidence of Haemorrhoids.....
- (h) Urine..SG.....Albumin.....Sugar.....
- (i) Any observable physical defects in addition to general record of observation:
If any please specify.....
- (j) Is the student on any treatment?.....
If any please specify.....
- (k) Blood KhanTest / VDRL.....
- (l) Any other observation of importance.....
.....

Medical Officer:

Address:**Stamp& Date:**.....

PART III

(To be completed by the University Chief Medical Officer)

Special Remarks.....
.....
.....

Is the Student fit for University Education? Yes/No

Date:.....

Chief Medical Officer
MMUST