



FAFA MEDICAL TRAINING COLLEGE

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www.fafamtc.com

STUDENT ADMISSIONS RECORD FORM

PART. A: STUDENTS PERSONAL DETAILS (To be filled by Student)

Date.....

Surname_____ Other Names_____

Date of Birth: _____ Nationality _____

Gender: Male Female (Tick as appropriate)

Religion_____

Postal Address: _____ Postal Code _____ Town _____

Tel. No: Home _____ Mobile _____

Email: _____

Citizenship _____ I.D./Passport
Number _____

Parent's/Guardian's Name _____

Relationship _____ Occupation _____

Postal Address: _____ Postal Code _____ Town _____

Home Tel: _____ Mobile: _____

EMERGENCY CONTACT PERSON

Name of Contact Person : _____

Relationship : _____

House Phone : _____

Mobile Phone : _____

MEDICAL HISTORY

Any medical condition which may be of concern: _____

Students Signature: _____ Date: _____

PART B: STUDENT ACADEMIC DOCUMENTS REVIEW *(To be filled by HEAD OF DEPARTMENT or Representative)*

KCSE Results *(Verify Originals and collect copies of ID, KCPE, and Leaving Certificate for filling)*

Mean Grade _____

Subject Scores as per Cluster Requirements for admission to the course *(Check course admission requirements guideline)*

Subject Requirement	Grade Requirement	Grade Attained
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Course Admitted _____

College Registration Number Assigned _____

I confirm that I have duly verified original documents and student duly qualifies for the course admitted.

Name _____ Signature: _____ Date: _____

**FAFA MEDICAL
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PART C: STUDENTS FEE PAYMENT (To be filled by **COLLEGE CASHIER** with issue of receipts each vote head with its own receipt book)

MODE OF STUDY

Tick	
	Boarder
	Day Scholar

Fee Payments

s/n	Particulars	Amount	Mode of Payment Cash / Bank		Receipt Issued (Tick)
1	Tuition				
2	Accommodation (Mandatory for Boarders)				
3	Meals (Mandatory for Boarders)				
4	Other Levies				
5	Council Levies (Mandatory)				
6	Admission fee				
7	Uniform				
8	Student ID				
9	Name plate				
10	Student Representative Council fee				
11	Hepatitis B vaccination fee				



PART D STUDENT FEE PAYMENT SUMMARY (To be filled by the **FINANCE OFFICER** or representative by confirmation of payment receipts)

COLLEGE FEE AND LEVIES PAID (*Refer to Revised Fee Structure*)

• **Tuition (Per Term / Per instalment)**

Amount Due _____ Amount Paid _____ Bal _____

Overpayment _____ Comment _____

• **Boarding** (*Per Month No Admission to boarding without full month Payment.*)

• **Meals**

Amount Due _____ Amount Paid _____ Bal _____

Overpayment _____ Comment _____

• **Accommodation** (*Per Month No Admission to boarding without Full month Payment*)

Amount Due _____ Amount Paid _____ Bal _____

Overpayment _____ Comment _____

• **Other Levies**

Amount Due _____ Amount Paid _____ Bal _____

Overpayment _____ Comment _____

• **Council Levies**

Amount Due _____ Amount Paid _____ Bal _____

Overpayment _____ Comment _____

Signature: _____

Date: _____

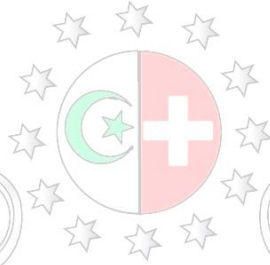
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NO STUDENT WILL BE ADMITTED WITHOUT THE FOLLOWING ITEMS.

DEAN OF STUDENTS-OTHER REQUIREMENTS CHECKLIST

KINDLY NOTE THAT, MATTRESS, BOOKS, PENS, FILES, GLOVES, RULED AND PHOTOCOPYING PAPERS, STETHOSCOPE MUST BE PURCHASED IN SCHOOL.

S/N	ITEM	PRICES	YES	NO	N/A
1	Original Letter of admission				
2	Original KCSE certificate or results slip				
3	Copies of Certificates submitted				
4	Reference letter from clergy				
5	Original national ID Card presented				
6	Copy of national ID submitted				
7	Filled up copy of health report submitted				
8	A letter from sponsor (<i>Where applicable</i>)				
9	Scientific calculator (<i>Where applicable</i>) and Stethoscope				
10	Portable electronic device (flash disc) and Nurses watch				
11	Personal effects clothes, blankets, sheets, towel, cup, spoon				
11	Mattress	2,500			
13	Writing materials (A4 Books A4 minimum 10), biro pen pencils and a rubber	@100/=			
14	Two colored passport size photograph submitted				
15	Closed low heeled back shoes				
16	Two spring files submitted	@70			
17	One ream POLAR ruled papers A4 size white in color submitted	@650			
18	Three reams of photocopying A4 size white in color PAPERLINE	@850			
19	3 boxes of clean gloves	@600			
20	NCK Fee Ksh. 9,400 paid on Admission day to Nursing Council Of Kenya (guidance will be given, for Nurses only)				
21	COC Fee Ksh. 7,500 paid on Admission day to Clinical Officers Council Of Kenya (guidance will be given, for clinical medicine students only)				
22	Students required to pay attachment fee at the Clinical Placement Area ,which varies with hospital policies				
23	Dust/Lab Coat (WHITE for male students)				
24	Theatre Scrubs (for perioperative theatre technology students only)				
25	Crocs Shoes				
26	Apron (WHITE)for female students				



Hostel Allocation

Room Number _____

Issue Copy of School Rules

Issued

Not Issued

Student Sign.....

Date.....

Dean of Students Comments

Signature _____

Date _____

Deputy Principals Review

Comments _____

Signature _____

Date _____

FMTTC

FAFA MEDICAL
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MEDICAL FORM

Certificate of Medical Examination

(Students are expected to present this form to a registered medical practitioner who shall conduct examination and duly fill in the form)

Personal Data

Name: Date of Birth:
 Cell Phone Number: ID NO / Birth Cert NO
 Course Campus
 College Number Home County
 Next of kin Relationship (father /mother / spouse /guardian)
 Cell Phone no

Medical History

- Have you been vaccinated for;

	Yes (Fully Vaccinated	Yes (partially Vaccinated)	Not Vaccinated		Yes (Fully Vaccinated	Yes (Partially Vaccinated)	Not Vaccinated
Covid 19*				Tetanus			
Hepatitis B				Polio			
BCG				Meningitis			
Influenza				Pneumonia			
Typhoid fever				Measles			
Mumps				HPV			
Diphtheria							

*Type (Aztar Zeneca, Moderna, Pfizer, Johnson and Johnson, Sputnik)

- Have you been treated for any chronic disease in the last one year? YES/NO
- If yes, which disease.....
- Are you currently on any treatment? YES/NO If yes; state for which condition
And on which medication /treatment
- Do you have food /drug allergy YES/NO.?If yes, state.....
- Last menstrual period (Female)

Family /Social Medical History

- Has any member of your family suffered from any of the following diseases;

Condition	Yes	No	Condition	Yes	NO
Diabetes Mellitus			Mental illness		
Hypertension			Cancer		
Epilepsy			Asthma		
Heart attack			Rheumatoid arthritis/SLE		
Stroke					

- In the last three (3) months, have you been in contact with someone who has;
 - Tuberculosis YES/NO
 - Hepatitis/jaundice YES/NO
 - Covid 19 YES/NO

Any other additional information/Comment.....

I.....declare that the information given above is true detail of my health history.

Date.....Sign.....

Physical Examination Findings;

- General Examination;**

.....
.....

- Vital Signs;**

	Findings	Comment
Blood Pressure		
Respiratory		
Pulse Rate		
Height		
Weight		
BMI		

- Eye: Vision RT.....LT.....Visual Acuity.....Colour.....
- Ear,Nose and Throat;.....
- Oral /Dental:.....
- Cardiovascular System:.....
- Respiratory System:.....
- Par Abdomen:.....
- Central Nervous System:.....
- Musculo-skeleton;.....

Laboratory / Radiological investigations;

TEST	Result	Comment
Stool for O/C		
Urinalysis		
Pregnancy test		
Chest X Ray		

Comment:

.....

Conclusion;.....has been examined and he/she is medically fit /unfit.

Examined by:.....Reg.No.....Sign/Stamp.....Date.....

NB: The form is to be filled and signed by a registered medical doctor /practitioner

Note:

- The information captured in this form will be held in strict confidence and will not be shared to a third party.
- The information given in this form shall not form the basis of admission, but the information will be used to inform the management of the student while in campus.

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