



KAIMOSI FRIENDS UNIVERSITY (KAFU)
Office of Registrar (Academic Affairs)

**AFFIX
COLOURED
PASSPORT
SIZE PHOTO
HERE**

Tel: 0773040235
E-mail: registrar_aa@kafu.ac.ke
Website www.kafu.ac.ke

P.O. Box 385
Kaimosi- 50309

Kenya

SECTION A

STUDENTS PERSONAL DETAILS

Information in this form is intended to help the Office of the Registrar understand the student better. It will be used for purposes of improving the Student's Welfare While at the University

(To be completed in written in CAPITAL/BLOCK letters or TICK where appropriate)

1 Name: _____

2. National ID: _____ County: _____

3. University Registration Number

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 Ethnicity: _____

Year of Study 1. First 2. Second 3. Third 4. Fourth 5. Fifth

Date of Birth: _____
 Day Month Year

4. Religion 1. Protestant 2. Catholic 3. Muslim 4. Others Others
Specify: _____

5. Nationality 1. 2. East African 3. Kenyan 4. Others Specify

6. Home contact address (where you can be contacted during vacations)

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 CODE

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 TOWN _____

TELEPHONE / MOBILE NO: _____

EMAIL: _____

7. (a) Marital Status 1. Single 2. Married

(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 _____ 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 TELEPHONE (LANDLINE) MOBILE PHONE E-MAIL ADDRESS

P.O. BOX (SURNAME) (FIRST NAME) (INITIAL/OTHER)
TOWN/CITY _____

(ii)

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.					
3.					

17. KACE Results/"A" Level Results (Subject and Grades)

18. Any other Institutions attended and Qualifications attained

	NAME	SPECIALIZATION	QUALIFICATIONS
1.			

I certify that the information I have provided is correct.

Signature: _____

Date: _____



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Office of the Dean of Students

SECTION B

BOND

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

I hereby bond myself to be of good conduct during my stay at the Kaimosi Friends University.

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

Failure to adhere to the above, the Kaimosi Friends University.
will reserve the right to institute disciplinary procedures against me.

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

Signed:
(Dean of Students)

Rubber Stamp.....



KAIMOSI FRIENDS UNIVERSITY (KAFU)

Games and Sports Department

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	Province	National	International	
1	Soccer						
2	Netball						
3	Volleyball						
4	Handball						
5	Rugby						
6	Athletics-track/field						
7	Basketball						
8	Chess, darts Scrabble						
9	Tennis						
10	Martial arts						
11	Swimming						
12	Hockey						
13	Badminton						
14	Table tennis						
OTHERS							
1							
2							
3							
4							

Signed.....

Date.....



KAIMOSI FRIENDS UNIVERSITY (KAFU)

ENTRANCE MEDICAL EXAMINATION**SECTION C****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) Surname.....Other Names.....D
 Date of birthSexNationality.....Race.....
 Religion.....Marital Status.....
 Faculty/School.....**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
 (x) 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) Smallpox? 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.....

Signature of Student: _____ Date: _____

PART II

(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:

(f) Lymphatic glands.....

(g) 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

Chief Medical Officer For: KAFU.

Name: _____ Sign: _____ Date: _____