NIGERIAN COLLEGE OF AVIATION TECHNOLOGY, ZARIA
AEROMEDICAL CENTRE

TRAINAIR PLUS ICAO REGIONAL CENTRE OF EXCELLENCE

AMC HEALTH INFORMATION FORM

(*Sections A & B to be completed by the Student while C & D at the Aeromedical Centre*)

Date: ……………………………………………….

A. BIODATA:

Name:

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Surname *First name* *Middle name*

Age: …………. (yrs.) Sex: M / F Marital Status: ………..…… PF/Reg. No……………………………………………….

Address/School/Room No.: …………………………………………………………………………………………………….

Occupation/Course: ……………………………….…………………………………………………………………………….

Phone Number: …….

Name of Next-of-Kin: ……………………………….………………………………………………………………………….

Address of Next-of-Kin: …………………………….…………………………………………………………………………….

Relationship with Next-of-Kin: …………………………..…………………………………………………………………………

Phone Number of Next-of-Kin: ……………………….……………………………………….…………………………………….

B. TRAVEL HISTORY:

Last Place of Departure: …………………………… Date of Departure: ………………… Date of Arrival:.…………………….

C. VITAL SIGNS:

- Blood Pressure (BP) ………………………….mmHg
- Pulse Rate (PR) ……………………………….bpm
- Temperature (T°)………………………………°C

D. SYMPTOM(S):

Symptom		
1. Cough:	YES ☐	NO ☐
2. Fever:	YES ☐	NO ☐
3. Shivering/shaking/chills:	YES ☐	NO ☐
4. Headaches:	YES ☐	NO ☐
5. Sore Throat:	YES ☐	NO ☐
6. Recent loss of taste or smell:	YES ☐	NO ☐
7. Difficulty in breathing:	YES ☐	NO ☐
8. Shortness of breath:	YES ☐	NO ☐
9. Diarrhea:	YES ☐	NO ☐
10. Abdominal pain:	YES ☐	NO ☐
11. Running nose/catarrh:	YES ☐	NO ☐
12. Fatigue:	YES ☐	NO ☐

Others, *please specify*: …………………………….……………………………………………………………………….

Signature (Student): …………………………………………………… Date: …………..……..…………………………….

Health Worker's Name: ……………………………………………… Sign & Date: ….……………………………………