Ministry of Health & Wellness / Ministry of Education Youth and Information School Health Programme

STUDENT'S MEDICAL REPORT

Part A: To be completed by the Parent/Guardian

NAME OF SCHOOL: _____

ACADEMIC YEAR: _____

PERSONAL DATA

STUDENT'S NAME (first, middle, last): _____

DATE OF BIRTH: _____ AGE:_____YRS SEX: M ☐ F ☐

dd/mm/yyyy

ADDRESS:_____

_____

FAMILY DOCTOR OR HEALTH CENTRE: _____

NAME OF **MOTHER**: _____

ADDRESS: (H)_____

ADDRESS: (W)_____

TELEPHONE NO: (W)_____ (H) _____(Cell)_____

EMAIL ADDRESS:_____

NAME OF **FATHER**: _____

ADDRESS: (H)_____

ADDRESS: (W)_____

TELEPHONE NO: (W)_____ (H) _____(Cell)_____

EMAIL ADDRESS:_____

NAME OF **GUARDIAN** OR PERSON WITH WHOM THE CHILD LIVES (if different from above):

_____ RELATIONSHIP: _____

ADDRESS: (H)_____

ADDRESS: (W)_____

TELEPHONE NO: (W)_____ (H) _____(Cell)_____

EMAIL ADDRESS:_____

EMERGENCY CONTACT INFORMATION (Persons to be contacted if parents cannot be reached)

1) **NAME:**_____ RELATIONSHIP_____

ADDRESS: _____

TELEPHONE NO: (W)_____ (H) _____(Cell)_____

EMAIL ADDRESS:_____

2) **NAME**:_____ RELATIONSHIP_____

ADDRESS: _____

TELEPHONE NO: (W)_____ (H) _____(Cell)_____

EMAIL ADDRESS:_____

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STUDENT'S MEDICAL REPORT

Part B: To be completed by a Physician or Family Nurse Practitioner and certified by the Physician

MEDICAL HISTORY

Please respond by putting a tick (✔) under the appropriate column and record dates of last treatment and remarks for positive responses.

Has your child ever been diagnosed or treated for any of the following conditions?

PAST HISTORY	YES	NO	DATE(s)	REMARKS
❖ Asthma/ Bronchitis	( )	( )	----------	----------
❖ Rheumatic Fever/Rh. Heart Disease	( )	( )	----------	----------
❖ Congenital/other Heart Disease	( )	( )	----------	----------
❖ Sickle Cell Disease	( )	( )	----------	----------
❖ Seizures	( )	( )	----------	----------
❖ Fainting spells/giddiness	( )	( )	----------	----------
❖ Anaemia	( )	( )	----------	----------
❖ Disorders of the Ears, Nose, Throat	( )	( )	----------	----------
❖ Diabetes Mellitus	( )	( )	----------	----------
❖ Hypertension	( )	( )	----------	----------
❖ High Cholesterol	( )	( )	----------	----------
❖ Arthritis	( )	( )	----------	----------
❖ Recurrent headaches/Migraine	( )	( )	----------	----------
❖ Visual or hearing disorders	( )	( )	----------	----------
❖ Physical Disability	( )	( )	----------	----------
❖ Psychological disorder (e.g. post- traumatic stress disorder)	( )	( )	----------	----------
❖ Infectious diseases	( )	( )	----------	----------
❖ Allergies to: Penicillin/antibiotics	( )	( )	----------	----------
• Any other substance	( )	( )	----------	----------
❖ Any other condition	( )	( )	----------	----------

Has your child ever been admitted to hospital or had surgery? YES ☐ NO ☐

If yes, please explain for what reason & give dates. _____

_____

_____

Is your child taking any medications? YES ☐ NO ☐

If yes, please list (with frequency and duration). _____

Menarche: YES ☐ NO ☐ N/A ☐ If yes, LMP:_____

Has your daughter ever experienced dysmenorrhea? YES ☐ NO ☐ If yes, please state medication prescribed for same: _____

EMOTIONAL HISTORY

Has your child ever been diagnosed with the following?

	YES	NO	DATE(s)	REMARKS
Depression	( )	( )	_____	_____
Learning Disability	( )	( )	_____	_____
Hyperactivity (ADHD)	( )	( )	_____	_____
Behaviour disorder	( )	( )	_____	_____
Anxiety	( )	( )	_____	_____

Has your child experienced the following?	YES	NO
Recent stress e.g. death or relocation of a close family member, relative or friend	( )	( )
Difficulty making friends, adjusting to new situations	( )	( )
Difficulty concentrating in class	( )	( )
History of fighting /hurting others	( )	( )
Use of any of the following substances (alcohol, cannabis (ganja), cigarettes, Crack /cocaine, inhalants (e.g. sniffing glue), other)	( )	( )

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STUDENT'S MEDICAL REPORT

Explain:_____

_____

FAMILY HISTORY

	YES	NO	DATE(s)	REMARKS
❖ Diabetes Mellitus	( )	( )	----------	----------
❖ Hypertension	( )	( )	----------	----------
❖ Heart Disease/Stroke	( )	( )	----------	----------
❖ Sickle Cell Disease	( )	( )	----------	----------
❖ Mental Illness	( )	( )	----------	----------
❖ Cancer	( )	( )	----------	----------
❖ Other, state	( )	( )	----------	----------

MEDICAL EXAMINATION

Please give details of findings and verify immunization history

STUDENT'S NAME: _____

HEIGHT: _____cm WEIGHT: _____kg. BMI (Kg/m^2):_____
(Calculate BMI: Eg. If, Wt. = 35 KG Ht. = 120 cm [1.20m] BMI = 35 ÷ [1.20mx 1.20m] = 24.3)

BMI-FOR-AGE (use chart for interpretation): _____

WAIST CIRCUMFERENCE: _____cm BP: _____

GENERAL APPEARANCE: _____

NUTRITIONAL STATUS: _____ POSTURE: _____

SKIN: _____TEETH/GUMS: _____

HAIR/SCALP: _____

EYES: _____ VISION: R L
(Indicate whether tested with glasses or not)

EARS: _____HEARING: _____

NOSE/THROAT: _____

BREASTS: _____

THYROID: _____

RESPIRATORY SYSTEM: _____

CARDIOVASCULAR SYSTEM: _____

ABDOMEN/GI SYSTEM: _____

CENTRAL NERVOUS SYSTEM: _____

BONES AND JOINTS: _____

GENITOURINARY SYSTEM: _____

DEFORMITIES/DISABILITIES: _____

URINALYSIS: PROTEIN: _____GLUCOSE: _____

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STUDENT'S MEDICAL REPORT

BLOOD: _____ LEUCOCYTES: _____ OTHER: _____

HAEMOGLOBIN (for all grade 7 students): _____

IMMUNIZATION HISTORY

Please indicate dates vaccines were received:

	DATES ADMINISTERED					
Vaccine	**1st**	**2nd**	**3rd**	**Booster 1**	**Booster 2**	**Booster 3**
BCG						
DPT/DT						
Polio						
MMR						
Chicken Pox						
Hep B						
Hib						
Pneumococcal						
HPV						
Other:						
Other:						
Other:						

***Please provide a copy of the immunization card for the school records**

OUTSTANDING DOSES?: YES ☐ NO ☐

If Yes, specify: _____

ASSESSMENT

KEY FINDINGS: _____
_____

REFERRAL/FOLLOW UP REQUIRED: YES ☐ NO ☐

If Yes, specify: _____
_____

ADDITIONAL REMARKS & RECOMMENDATIONS: _____
_____

PHYSICAL ACTIVITY: UNRESTRICTED ☐ AS TOLERATED ☐ LIMITED ☐

If Limited, reason: _____
_____
_____

CERTIFIED FIT FOR ADMISSION TO SCHOOL: YES ☐ NO ☐

_____ _____
NURSE PRACTITIONER'S SIGNATURE ADDRESS

_____ _____ _____
NURSE PRACTITIONER'S NAME (WRITTEN) NCJ REG. # DATE

(and/or)

_____ _____
DOCTOR'S SIGNATURE ADDRESS

_____ _____ _____
DOCTOR'S NAME (WRITTEN) MCJ REG. # DATE

(please affix stamp)

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STUDENT'S MEDICAL REPORT

CONSENT TO MEDICAL TREATMENT

Dear Parent/ Legal Guardian,

While your child/ward is at …….. …… it may
(Name of School)

become necessary to treat him/her for any health need/emergencies which may occur during school hours. In cases of emergencies, attempts will be made to contact you urgently; however, for our health professional/s to administer care to your child/ward, your consent is required.

Kindly complete the consent form below and return it with the remainder of the medical.

Thank you.

Yours sincerely,

……..
PRINCIPAL

Authorization.

To be completed by a parent or a legal guardian with the Nurse or Doctor

I……. hereby give/ do not give my consent for
(Name of Parent/ Legal Guardian)

health care/ treatment to be given to ----------
(Name of Child)

in the event of any such need / emergency arising at ----------
(Name of School)

SIGNATURE: …… ……
(Parent/ Legal Guardian) Witnessed by, Nurse (RN) / Doctor

DATE: …….. **DATE:** ……

MY CONTACT: ----------

HOME ADDRESS: ----------

WORK ADDRESS: ----------

HOME PHONE NO: …… WORK PHONE NO: …… CELL NO.……Email……

OUR FAMILY DOCTOR IS:

NAME: ----------

ADDRESS: ----------
TELEPHONE NO:----------

NB. Nurses/Principals - this sheet must be copied and accompany the student to health facilities, when being taken from school.