Ministry of Education, Youth and Information/Ministry of Health
School Health Programme

STUDENT S MEDICAL REPORT

Revised 6/2019 -

Part A **TO BE COMPLETED AND SIGNED BY PARENT/ LEGAL GUARDIAN**

NAME OF SCHOOL: _____

ACADEMIC YEAR: _____

STUDENT S PERSONAL DATA

STUDENT S NAME: _____ (First / Middle / Last)

DATE OF BIRTH: _____ (Day / Month) _____ (Year) AGE: _____ YRS SEX: M ☐ F ☐

STUDENT S ADDRESS: _____

_____

NAME OF MOTHER: _____

ADDRESS: (H) _____

ADDRESS: (W) _____

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

NAME OF FATHER: _____

ADDRESS: (H) _____

ADDRESS: (W) _____

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

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

_____

ADDRESS: (H) _____

ADDRESS: (W) _____

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

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

1) NAME: _____ RELATIONSHIP (to child) _____

ADDRESS: _____

TELEPHONE NO(s): _____ Email: _____

2)NAME: _____ RELATIONSHIP (to child) _____

ADDRESS: _____

TELEPHONE NO(s): _____ Email: _____

ANY OTHER PERSONAL DATA/ OTHER EMERGENCY CONTACT/ OR OTHER INFORMATION

NB. Please put parents names even if deceased or overseas and indicate.

MEDICAL HISTORY

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

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

PAST HISTORY	YES	NO	DATE(s)	REMARKS
v Asthma/ Bronchitis/Wheezing	( )	( )	_____	_____
v Rheumatic Fever/Rh. Heart Disease	( )	( )	_____	_____
v Congenital / other Heart Disease	( )	( )	_____	_____
v Sickle Cell Trait/Disease	( )	( )	_____	_____
v Seizures (Epilepsy /Fits)	( )	( )	_____	_____
v High Blood Pressure	( )	( )	_____	_____
v Fainting spells/giddiness	( )	( )	_____	_____
v Anemia (weak blood)	( )	( )	_____	_____
v Excess Tiredness	( )	( )	_____	_____
v Disorders of the Ears, Nose, Throat	( )	( )	_____	_____
v Diabetes Mellitus (Sugar)	( )	( )	_____	_____
v Chronic Disease (e.g. Cancer/Thyroid)	( )	( )	_____	_____
v Arthritis	( )	( )	_____	_____
v Recurrent headaches/Migraine	( )	( )	_____	_____
v Visual or hearing disorders	( )	( )	_____	_____
v Physical Disability	( )	( )	_____	_____
v Infectious diseases (e.g. measles, Tuberculosis (TB), mumps, typhoid)	( )	( )	_____	_____
v Allergies to: **Penicillin/antibiotics**	( )	( )	_____	_____
Any other substance	( )	( )	_____	_____
v Any other condition	( )	( )	_____	_____

HAS YOUR CHILD EVER BEEN ADMITTED TO HOSPITAL ☐ OR HAD SURGERY? ☐

IF YES, PLEASE EXPLAIN FOR WHAT REASON & GIVE DATE(S):_____

_____

REGULAR MEDICATIONS TAKEN (IF ANY):_____

EMOTIONAL HISTORY

Has your child ever been diagnosed with or tested for the following? **Please indicate in the remarks column –(D) for diagnosed with or (T) for tested for, if applicable.**

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

HAS YOUR CHILD EXPERIENCED ANY OF 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	( )	( )
Any other situation which may be of concern to, or likely to affect you or the child	( )	( )

Explain:_____

_____

_____

FAMILY HISTORY

Has any family member been diagnosed with the following?

	YES	NO	REMARKS
v Allergies to medication/foods etc.	( )	( )	_____
v Mental Disorder	( )	( )	_____
v Sickle Cell Disease/Trait	( )	( )	_____
v Migraine	( )	( )	_____
v Hypertension (High Blood Pressure)	( )	( )	_____
v Diabetes Mellitus (Sugar)	( )	( )	_____
v Heart Disease / Heart Condition	( )	( )	_____

I certify that the above information is correct.

SIGNATURE:_____ **DATE:**_____

PART B

MEDICAL EXAMINATION REPORT

To be completed by a Physician or Family Nurse Practitioner

Please note that all investigations and findings are to be recorded on this file. This will ensure the School Nurse's ability to follow-up on issues throughout the school year.

STUDENT S NAME: _____

DATE OF BIRTH: _____ AGE _____

HEIGHT: _____ cm WEIGHT: _____ kg. B.M.I. = _____

TEMP. _____ PULSE _____ RESP. _____ B.P. _____

MENARCHE: YES ☐ NO ☐ If yes, L.M.P: _____

DYSMENORRHEA: YES ☐ NO ☐ If yes, Medication prescribed for same _____

GENERAL APPEARANCE: _____

NUTRITIONAL STATE: _____ POSTURE: _____

SKIN: _____ TEETH/GUMS: _____

HAIR/SCALP: _____

EYES: _____ VISION: R L
(Tested with glasses/ without glasses)

EARS: _____ HEARING: _____

NOSE/THROAT: _____

BREASTS: _____

THYROID: _____

RESPIRATORY SYSTEM: _____

CARDIOVASCULAR SYSTEM: _____

ABDOMEN/GI SYSTEM: _____

CENTRAL NERVOUS SYSTEM: _____

BONES AND JOINTS: _____

DEFORMITIES/DISABILITIES: _____

GENITO URINARY SYSTEM: _____

URINANLYSIS: **PROTEIN:** _____ **SUGAR:** _____ **OTHER** _____

OTHER INVESTIGATIONS INDICATED: _____
(Follow up report to be provided)

_____

_____

_____

Immunization History: Please indicate dates vaccines received.

Vaccine	DOSES				
	1st	2nd	3rd	Booster 1	Booster 2
BCG					
DPT/DT					
Polio					
MMR					
Chicken Pox					
Hep. B					
Hib					
Pneumovax					
Other:					
Other:					

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

REMARKS AND RECOMMENDATIONS / TREATMENT GIVEN OR RECOMMENDED:
NB. Please provide standing orders for any medications used for chronic conditions.

_____

_____

_____

_____

PHYSICAL ACTIVITY: UNRESTRICTED ( )

AS TOLERATED ( )

LIMITED ( )

IF LIMITED, GIVE REASON: _____

_____

CERTIFIED FIT FOR ADMISSION TO SCHOOL: YES ( ) NO ( ) PENDING ( )

IF PENDING OR NO, EXPLAIN _____

_____

_____ _____

DOCTOR S SIGNATURE ADDRESS OF HEALTH FACILITY

_____ _____ _____

DOCTOR S NAME (PRINT) MCJ REG. # DATE

(Please affix stamp)

OR:

_____ _____

NURSE PRACTITIONER S SIGNATURE ADDRESS OF HEALTH FACILITY

_____ _____ _____

NURSE PRACTITIONER S NAME (PRINTED) NCJ REG # DATE

CONSENT TO MEDICAL TREATMENT

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

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.

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.