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: (W) _____
   TELEPHONE NO: (W) _____ (H) _____(Cell_____
   EMAIL ADDRESS: _____
2) **NAME:** _____RELATIONSHIP: _____
   ADDRESS: (W) _____
   TELEPHONE NO: (W) _____ (H) _____(Cell_____
   EMAIL ADDRESS: _____

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STUDENT'S MEDICAL REPORT

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

MEDICAL HISTORY

Please respond by putting 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/ Rheumatic Heart disease	( )	( )	_____	_____
➢ Congenital/other Heart Disease	( )	( )	_____	_____
➢ Sickle Cell trait/Disease	( )	( )	_____	_____
➢ Seizure(epilepsy/Fit)	( )	( )	_____	_____
➢ Fainting spells/giddiness	( )	( )	_____	_____
➢ Anemia (weak blood)	( )	( )	_____	_____
➢ Hypertension	( )	( )	_____	_____
➢ Disorders of the ear , nose ,throat	( )	( )	_____	_____
➢ Diabetes Mellitus (sugar)	( )	( )	_____	_____
➢ High Cholesterol	( )	( )	_____	_____
➢ Arthritis	( )	( )	_____	_____
➢ Recurrent headaches/migraine	( )	( )	_____	_____
➢ Visual or hearing disorders	( )	( )	_____	_____
➢ Physical Disability	( )	( )	_____	_____
➢ Psychological disorder (e.g. post traumatic stress disorder)	( )	( )	_____	_____
➢ Infectious disease	( )	( )	_____	_____
➢ Allergies to: Penicillin /antibiotic	( )	( )	_____	_____
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 and 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 child ever experienced dysmenorrheal? **YES ( ) NO ( )** If yes, please state the medication prescribed for same: _____

EMOTIONAL HISTROY

Has your child ever been diagnosed with any of the following?

	YES	NO	DATE(s)	REMARKS
➢ Depression	( )	( )	_____	_____
➢ Learning disabilities	( )	( )	_____	_____
➢ Behavioral disorder	( )	( )	_____	_____
➢ Hyperactivity (ADHD)	( )	( )	_____	_____
➢ Anxiety	( )	( )	_____	_____

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STUDENT'S MEDICAL REPORT

Has your child ever experienced the following?

	YES	NO
➢ Recent stress eg. or relocation of a close family, relative or friend	( )	( )
➢ Difficulty making friends , adjusting to new situations	( )	( )
➢ Difficulty concentrating in class	( )	( )
➢ History of fighting /hurting others	( )	( )
➢ Use of the following substances (alcohol, cannabis, (ganga), Cigarettes, crack/cocaine, inhalants (e.g. sniffing glue, other	( )	( )

Explain: _____
_____

FAMILY HISTORY

	YES	NO	DATE(s)	REMARKS
➢ Diabetes Mellitus	( )	( )	_____	_____
➢ Hypertension	( )	( )	_____	_____
➢ Sickle Cell disease	( )	( )	_____	_____
➢ Heart Disease/Stroke	( )	( )	_____	_____
➢ 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 ÷ (1.20m x 1.20m) = 24.3)

MBI-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?: _____

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 FIR 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 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 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.