

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: _____

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?

<u>PAST HISTORY</u>	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)	()	()

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/m²): _____
(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: _____



STUDENT'S MEDICAL REPORT

BLOOD: _____ LEUCOCYTES: _____ OTHER: _____

HAEMOGLOBIN (for all grade 7 students): _____

IMMUNIZATION HISTORY

Please indicate dates vaccines were received:

Vaccine	DATES ADMINISTERED					
	1 st	2 nd	3 rd	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)

Dear Parent/ Legal Guardian,

JAMAICA COLLEGE

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.