Ministry of Health & Wellness / Ministry of Education Youth

and Information School Health Programme

STUDENT'S MEDICAL REPORT

CONSENT TO MEDICAL TREATMENT

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 JAMAICA COLLEGE
(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.

MINISTRY OF HEALTH & WELLNESS 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 GENDER: Male

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) _ _ _ _ _ _ _ _ _ _(C)_ _ _ _ _ _ _

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) _ _ _ _ _ _ _ _ _ _ _ _ _ (C)_ _ _ _ _ _ _ _ _ _ _ _

EMAIL ADDRESS: _

MINISTRY OF HEALTH & WELLNESS Ministry of Health & Wellness / Ministry of Education Youth and Information School Health Programme

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	( )	( )	_____	
• Anemia	( )	( )	_____	
• 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). _

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:……
……

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

STUDENT'S MEDICAL REPORT

FAMILY HISTORY

	YES	NO	Relative
• Diabetes Mellitus	( )	( )	___________
• Hypertension	( )	( )	___________
• Heart Disease	( )	( )	___________
• Stroke	( )	( )	___________
• Sickle Cell Disease	( )	( )	___________
• Mental Illness	( )	( )	___________
• Cancer	( )	( )	___________
• Other, state	( )	( )	___________

REMARKS: ____

MEDICAL EXAMINATION

Please give details of findings and verify immunization history

STUDENT'S NAME: _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

HEIGHT: _ _ _ _ _ _ _ cm WEIGHT: _ _ _ _ _ _ kg. BMI (Kg/ m^2) : _ _ _

BMl-FOR-AGE (use chart for interpretation): _ _ _ _ _ _ _ _ _ _ _ _ _

WAIST CIRCUMFERENCE _ _ _cm BP: _ _ _ _ _ _ _ _ mmHg

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: _

PECTORALS: _

THYROID: _

RESPIRATORY SYSTEM: _

CARDIOVASCULAR SYSTEM: _

ABDOMEN/GI SYSTEM: _

CENTRAL NERVOUS SYSTEM: _

BONES AND JOINTS: _

GENITOURINARY SYSTEM: _

DEFORMITIES/DISABILITIES: _

URINALYSIS: PROTEIN: _ _ _ _ _ _ _ _ _ _ GLUCOSE: _ _ _ _ _ _ _ _ _ _

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

STUDENT'S MEDICAL REPORT

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 PRACTITIGNER'S NAME (WRITTEN) NCJ REG. # DATE

(and/or)

_____ _____

DOCTOR'S SIGNATURE ADDRESS

_____ _____ _____

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

(please affix stamp)