

Immunization History: Please indicate dates vaccines received.

Vaccine	DOSES				
	1 st	2 nd	3 rd	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: _____

PHYSICAL ACTIVITY: UNRESTRICTED ()

 AS TOLERATED ()

 LIMITED ()

If Limited, reason: _____

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

DOCTOR'S SIGNATURE

ADDRESS

DOCTOR'S NAME (WRITTEN)

MCJ REG. #

DATE

OR:

NURSE PRACTITIONER'S SIGNATURE

ADDRESS OF HEALTH CENTRE

NURSE PRACTITIONER'S NAME (WRITTEN)

NCJ REG #

DATE

Ministry of Education/Ministry of Health**School Health Programme****Student's Medical Report****MAGGOTTY HIGH SCHOOL****Part A TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN**

NAME OF SCHOOL: _____

ACADEMIC YEAR: _____

PERSONAL DATA

STUDENT'S NAME: _____

DATE OF BIRTH: _____ AGE: _____ YRS SEX: M F ADDRESS: _____

TELEPHONE NO: _____

NAME OF PARENT/GUARDIAN: _____

ADDRESS: (H) _____

ADDRESS: (W) _____

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

EMERGENCY CONTACT INFORMATION

NAME: _____ RELATIONSHIP _____

ADDRESS: _____

TELEPHONE NO(s): _____

FAMILY DOCTOR OR HEALTH CLINIC: _____

ADDRESS: _____

TELEPHONE NO: _____

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 Trait/Disease	()	()	-----	-----
❖ Seizures (Epilepsy /Fits)	()	()	-----	-----
❖ Fainting spells/giddiness	()	()	-----	-----
❖ Anaemia(weak blood)	()	()	-----	-----
❖ Excess Tiredness	()	()	-----	-----
❖ Disorders of the Ears, Nose, Throat	()	()	-----	-----
❖ Diabetes Mellitus (Sugar)	()	()	-----	-----
❖ Chronic Disease(eg Cancer/Thyroid)	()	()	-----	-----

	YES	NO	DATE(s)	REMARKS
❖ Arthritis	()	()	-----	-----
❖ Recurrent headaches/Migraine	()	()	-----	-----
❖ Visual or hearing disorders	()	()	-----	-----
❖ Physical Disability	()	()	-----	-----
❖ Infectious diseases (e.g. measles, tuberculosis (TB), mumps, typhoid)	()	()	-----	-----
❖ 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. _____

REGULAR MEDICATIONS TAKEN (IF ANY): _____

EMOTIONAL HISTORY

Has your child ever been diagnosed with the following?

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

Has your child experienced the following?

	YES	NO
Recent stress eg. 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	()	()

Explain: _____

FAMILY HISTORY

Has any family member been diagnosed with the following?

	YES	NO	REMARKS
❖ Allergies	()	()	_____
❖ Mental Disorder	()	()	_____
❖ Sickle Cell Disease	()	()	_____
❖ Migraine	()	()	_____

I certify that the above information is correct.

SIGNATURE: _____ DATE: _____
(PARENT/GUARDIAN)

PART B MEDICAL EXAMINATION REPORT

To be completed by a Physician or Family Nurse Practitioner

Please give details of findings and verify immunization history

STUDENT'S NAME: _____

DATE OF BIRTH: _____ AGE _____

HEIGHT: _____ cm WEIGHT: _____ kg. BP: _____

MENARCHE: YES No if yes, LMP: _____

General Appearance: _____

Nutritional State: _____ 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: _____

DEFORMITIES/DISABILITIES: _____

GENITO URINARY SYSTEM: _____

URINANALYSIS: PROTEIN: _____ SUGAR: _____

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