

Ministry of Education Youth and Culture/Ministry of Health School Health Programme

Student's Medical Report

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)	()	()	_____	_____
Behavior 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 and stamped by 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: _____

DEFORMITES/DISABILITIES: _____

GENITO URINARY SYSTEM: _____

URINANALYSIS: PROTEIN: _____ SUGAR: _____

OTHER INVESTIGATIONS INDICATED: _____
(Following up report to be printed)

IMMUNIZATION HISTORY: Please indicate dates vaccines received.

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

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