



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 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/m<sup>2</sup>): \_\_\_\_\_  
(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: \_\_\_\_\_



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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:

Vaccine	DATES ADMINISTERED					
	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	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)



**Ministry of Health & Wellness / Ministry of Education Youth  
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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 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:** ..... **Witnessed by, Nurse (RN) / Doctor**  
 (Parent/ Legal Guardian )

**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.**