Ministry of Education Youth and Culture/Ministry of Health

School Health Programme Student's Medical Report

TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN

Part A

NAME OF SCHOOL _____

ACADEMIC YEAR:_____

PERSONAL DATA

STUDENT'S NAME: _____

DATE OF BIRTH: _____ AGE: _____ YRS _____

SEX: M ( ) F ( )

ADDRESS: (H)_____

ADDRESS (W) _____

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

EMERGENCY CONTACT INFORMATION

NAME: _____

ADDRESS: _____

TELEPHONE NO (S): _____
FAMILY DOCTOR ORHEALTH 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)	( )	( )	_____	_____
Recurrent headaches/Migraine	( )	( )	_____	_____
Visual or hearing disorders	( )	( )	_____	_____
Physical Disability	( )	( )	_____	_____
Infectious diseases (eg. Measles, tuberculosis (TB), mumps typhoid)	( )	( )	_____	_____
Allergies to: Penicillin/ antibiotics				
Any other substance				
Any other condition	( )	( )	_____	_____

HAS YOUR CHILD EVERBEEN 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	( )	( )	_____	_____
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: _____