Denbigh High School

Student's Medical Report

Academic Year: _____

Section A: To be completed and signed by parent/guardian

PERSONAL DATA

Student's Name: _____

Date of Birth: _____ /_____ /_____ Age: _____Yrs Sex: M **[ ]** F **[ ]**

Parent/Guardian's Name: _____ _____

Address: _____

Contact: _____ _____ _____ _____

Home *Work* *Cell* *WhatsApp*

Email: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Address: _____

Contact: _____ _____ _____ _____

Home *Work* *Cell* *WhatsApp*

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 OF LAST TREATMENT**	**COMMENTS**
• Asthmas/Bronchitis	[ ]	[ ]	_____	_____
• Rheumatic Fever/ Rh. Heart Disease	[ ]	[ ]	_____	_____
• Congenital/ Other Heart Disease	[ ]	[ ]	_____	_____
• Sickle Cell Trait/Disease	[ ]	[ ]	_____	_____
• Seizures (Epilepsy/Fits)	[ ]	[ ]	_____	_____
• Fainting Spells/Giddiness	[ ]	[ ]	_____	_____
• Anemia (Weak Blood)	[ ]	[ ]	_____	_____
• Excess Tiredness	[ ]	[ ]	_____	_____
• Disorders of the Ear, Nose, Throat	[ ]	[ ]	_____	_____
• Diabetes Mellitus (Sugar)	[ ]	[ ]	_____	_____
• Chronic Disease (E.g. Cancer/Thyroid)	[ ]	[ ]	_____	_____
• Arthritis	[ ]	[ ]	_____	_____
• Recurrent Headaches/Migraine	[ ]	[ ]	_____	_____
• Visual or Hearing Disorders	[ ]	[ ]	_____	_____
• Physical Disability	[ ]	[ ]	_____	_____
• Infectious Diseases(E.g. Measles, Tuberculosis (TB), Mumps, Typhoid)	[ ]	[ ]	_____	_____
• Allergies	[ ]	[ ]	_____	_____
• Any other condition	[ ]	[ ]	_____	_____
• COVID19				

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	COMMENTS
• 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	COMMENTS
• Allergies	[ ]	[ ]	_____
• Mental disorder	[ ]	[ ]	_____
• Sickle cell disease	[ ]	[ ]	_____
• Migraine	[ ]	[ ]	_____
• Chronic Disease	[ ]	[ ]	_____

I _____ certify that the above information is correct.

Parent/Guardian's Full Name

Signature: _____ Date: _____

Parent/Guardian

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/Gum: _____

Hair/Scalp: _____

Eyes: _____ Vision: **R** **L**

(Indicate whether tested with glasses or not)

Ears: _____ Hearing: _____

Nose/Throat: _____

Breasts: _____

Thyroid: _____

Respiratory System: _____

Cardiovascular Systems: _____

Abdomen/GI System: _____

Central Nervous System: _____

Bones and Joints: _____

Deformities/Disabilities: _____

Genitourinary System: _____

Urinalysis: Protein: _____ Sugar: _____

Other investigations indicated: _____

(Follow up report to be provided)

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:					
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) *MCJ REG. #* *Date*