

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?

<u>PAST HISTORY</u>	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	[]	[]	_____

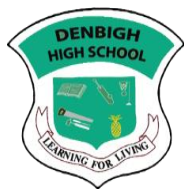
I _____ certify that the above information is correct.

Parent/Guardian's Full Name

Signature: _____

Parent/Guardian

Date: _____



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.

Vaccine	DOSES				
	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