Appendix I

Ministry of Education /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)_____ (Cel)_____

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	DATES(s)	REMARKS
Asthma/ Bronchitis	( )	( )	_____	_____
Rheumatic Fever/Rh. Heart Disease	( )	( )	_____	_____
Congenital / other Heart Disease	( )	( )	_____	_____
Sickle Cell Trait/Disease	( )	( )	_____	_____
Seizures (Epilepsy /Pits)	( )	( )	_____	_____
Fainting spells/giddiness	( )	( )	_____	_____
Anaemia(weak blood)	( )	( )	_____	_____
Excess Tiredness	( )	( )	_____	_____
Disorders of the Ears, Nose, Throat	( )	( )	_____	_____
Diabetes Mellitus (Sugar)	( )	( )	_____	_____
Chronic Disease (e.g. Cancer/Thyroid)	( )	( )	_____	_____

Part B

Medical Examination Report

To be completed by a physician or Family Nurse Practioner
Please give details of findings and verify immunization history

STUDENT NAME:_____

DATE OF BIRTH:_____ AGE: _____

HEIGHT:_____cm WEIGHT:_____kg BP: _____

MENARCHE YES [ ] NO [ ] if yes LMP _____

GENERAL APPEARANCE: _____

NUTRITION STATE:_____ POSTURE_____

SKIN:_____ TEETH/GUM:_____

HAIR/SCALP:_____

EYES:_____VISION: R [ ] L [ ]

(indicate whether tested with glasses or not)

EARS:_____ HEARING:_____

NOSE/ THROAT:_____

BREAST:_____

THYROID:_____

RESPIRATIRY SYSTEM:_____

CARDIVASCULAR SYSTEM:_____

ABDOMEN/GI SYSTEM:_____

CENTRAL NERVOUS SYSTEM:_____

BONES AND JOINTS:_____

DEFORMATIES/ DISABILITIES:_____

GENITO URINARY 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/D'T					
Polio					
MMR					
Chicken Box					
Hep. B					
Hib					
Pheumovax					
Other					
Other					

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