

# **MEDICAL REPORT**

Please fill the medical report with the required information. Section A is to be completed and signed by the student's parent/guardian whilst Section B is to be completed, signed and stamped by the health care provider.

### **SECTION** A (to be completed by parent/guardian)

Student Full Name						
Date of Birth Ge						
History Form						
Instity Form						
List past and current medical conditions.						
Have you ever had surgery? If yes, list all pas	t surgical proce	dures.				
Medicines and supplements: List all current n	nedications and	supplements (herl	oal and nutritional).			
Do you have any allergies? If yes, please list a	all your allergie	s (ie, medicines, p	ollens, food, stinging in	isects).		
Student Health Questionnaire						
	1 41 1 1			h - 1:41-	41	
(Over the last 2 weeks, how often have you be appropriate number)	en bothered by	any of the followi	ng problems? (Check the	ne box with	tne	
	Not At All	Several days	Over half the days	Nearly ev	ery day	
Feeling nervous, anxious, or on edge	[0]	[1]	[2]		[3]	
Not being able to stop or control worrying	[0]	[1]	[2]		[3]	
Little interest or pleasure in doing things	[0]	[1]	[2]	[3]		
Feeling down, depressed, or hopeless	[0]	[1]	[2]	[3]		
<b>General Health Questions</b>						
(Choose 'Yes' or 'No' as appropriate)						
1. Do you have any concerns that you would like to discuss with your provider?					[ No ]	
2. Has a provider ever denied or restricted your participation in sports for any reason?					[ No ]	
3. Do you have any ongoing medical issues or	recent illness?			[Yes]	[ No ]	

### **General Health Questions About You**

4. Have you ever passed out or nearly passed out during or after exercise?	[ Yes ] [ No ]			
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?				
6. Has a doctor ever requested a test for your heart? E.g. electrocardiography (ECG) or echocardiography.				
7. Do you cough, wheeze, or have difficulty breathing during or after exercise?	[ Yes ] [ No ]			
8. Have you ever had a seizure?	[ Yes ] [ No ]			
9. Have you had a head injury, temporary loss of consciousness, a prolonged headache, or memory loss?				
10. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?	[ Yes ] [ No ]			
11. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?				
13. Are you on a special diet or do you avoid certain types of foods or food groups?				
Parental Consent And Attestation				
I/We, the Undersigned hereby give consent for the administration of first aid services and non-prescribed drutereatment of minor illness or injury as provided by school nurses to the aforementioned student. Kindly tick non-prescribed drugs for administration from the list below:	•			
Syrup Paracetamol				
Syrup Buscopan				
Buscopan Tablet				
Syrup Piriton / Loratadine				
Syrup Ibuprofen				
ORS [Oral Rehydration Solution]				
Paracetamol Tablet				
Olbas oil [Inhalant Decongestant]				
Throat Lozenges				
I/We, the Undersigned hereby state that, to the best of my/our knowledge, the answers to the questions on th complete and correct.	is form are			
Name of Parent(s) /				
Guardian(s):				
Signature(s) and date:				

## SECTION B (to be filled by health care provider)

Students are required to be assessed by a health care provider annually and the assessment report is to provide feedback about the health status of each student. Kindly provide notes on the examination performed for each area. Specify normal where applicable.

Vitals				
Height	Height Weight		Pulse BP	
Vision				
R 20/	L 20/	Corrected: (Y/N)		
Medical				
Appearance	Eyes Check	Ears Check	Nose Check	
Throat Check	Lymph nodes	Heart Check	Respiratory Check	
Pulse (Simultaneous	femoral and radial pulses)	) Abdomen	Skin (HSV, lesions etc)	
Eligibility				
Kindly tick the appropriate chec	ckbox in relation to medica	al advice on sporting activities	for the student.	
Medically eligible for all	sports without restriction			
Medically eligible for all	sports with recommendation	ons for further evaluation or tr	eatment of	
Medically eligible for cert	ain sports such as			
Medically ineligible for a	ll sports pending further ev	valuation		
Medically ineligible for a	ny sports			

#### Attestation

**Health Care Provider Details** 

I have examined the student named on this form and provided the medical advice as indicated above. A copy of the physical examination findings are on record in my office. If conditions arise after the student has been cleared for participation in any sports, the physician may rescind the medical eligibility until the problem is resolved and potential consequences completely explained to the student (and parents or guardians).