Marcus Garvey Technical High School

Ministry of Education Youth and Culture/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: …… NAME OF FORM TEACHER : ……

PERSONAL DATA

STUDENT'S NAME: ……

DATE OF BIRTH: …….... AGE: ……YRS SEX: M ☐ F ☐

ADDRESS: ……

GRADE……..TELEPHONE NO: ……..

NAME OF PARENT/GUARDIAN: ……

ADDRESS: (H) ……

ADDRESS: (W) ……

TELEPHONE NO: (W) …… (H) …… (Cell) ……

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 date of last treatment a remarks for positive responses.

Has your child been diagnosed or treated for any of the following conditions?

PAST HISTORY	YES	NO	DATES	REMARKS
❖ Asthma	( )	( )	_____	_____
❖ Rheumatic fever	( )	( )	_____	_____
❖ Congenital/ Other Heart Disease	( )	( )	_____	_____
❖ Sickle Cell Trait/Disease	( )	( )	_____	_____
Seizures (Epilepsy/ Fits)	( )	( )	_____	_____
❖ Fainting Spells/Giddiness	( )	( )	_____	_____
❖ Anemia (Weak Blood)	( )	( )	_____	_____
❖ Excess Tiredness	( )	( )	_____	_____
❖ Disorders of the Ears, Nose, Throat	( )	( )	_____	_____
❖ Diabetes Mellitus	( )	( )	_____	_____

❖ Chronic Disease (e.g. Cancer/Thyroid)	( )	( )	_____	_____
❖ Arthritis	( )	( )	_____	_____
❖ Recurrent headaches/Migraine	( )	( )	_____	_____
❖ Visual or hearing disorder	( )	( )	_____	_____
❖ Physical Disability	( )	( )	_____	_____
❖ Infectious Disease (e.g. measles,	( )	( )	_____	_____
❖ tuberculosis (TB), mumps, Typhoid)				
❖ Allergies to: Penicillin/ antibiotics	( )	( )	_____	_____
❖ Any other substance				
❖ Any other conditions	( )	( )	_____	_____

HAS YOUR CHILD BEEN ADMITTED TO HOSPITAL OR HAD SURGERY YES ◯ NO ◯

If yes, please explain for what reason.

REGULAR MEDICATION TAKEN (IF ANY):

EMOTIONAL HISTORY

Has your child ever been diagnosed with any of the following?

	YES	NO	DATE(s)	REMARKS
Depression	( )	( )	_____	_____
Learning Disability	( )	( )	_____	_____
Hyperactivity (ADHD)	( )	( )	_____	_____
Behavior disorder	( )	( )	_____	_____

Has your child experienced the following?

	YES	NO
Recent stress e.g. Death or relocation of a 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: ……

(PARENT/GUARDIAN)

Marcus Garvey Technical High School

PART B

MEDICAL EXAMINATION REPORT

To be completed by a physician or Family 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 Status: …… Posture: ……

SKIN: …….. TEETH/GUMS: ……

HAIR/SCALP: ……

EYES: …….. VISION: R L

(Indicate whether tested with glasses or not)

EARS: …… HEARING: ……

NOSE/THROAT: ……

BREAST: ……

THYROID: ……

RESPIRATORY SYSTEM: ……

CARDIOVASCULAR SYSTEM: ……

ABDOMINAL/ GI SYSTEM: ……

CENTRAL NERVOUS SYSTEM: ……

BONE AND JOINTS: ……

DEFORMITIES/DISABILITIES: ……

GENITO-URINARY SYSTEM: ……

URINALYSIS: PROTEIN: …… SUGAR: ……

OTHER INVESTIGATION 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:					

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

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Doctor's Signature Date