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:__________________

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) ______________________(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 dates of last treatment and remarks for positive responses.

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

PAST HISTORY

	YES	NO	DATE(s)	REMARKS
Asthma/Bronchitis	( )	( )	__________	____________________
Rheumatic fever/Rh. Heart disease	( )	( )	__________	____________________
Congenital/ other Heart Disease	( )	( )	__________	____________________
Sickle Cell trait/disease	( )	( )	__________	____________________
Seizures (Epilepsy/Fits	( )	( )	__________	____________________
Fainting spells/giddiness	( )	( )	__________	____________________
Anaemia weak blood)	( )	( )	__________	____________________
Excess Tiredness	( )	( )	__________	____________________
Disorders of the Ears, Nose, Throat	( )	( )	__________	____________________
Diabetes mellitus(Sugar)	( )	( )	__________	____________________
Chronic Disease (eg Cancer/ Thyroid	( )	( )	__________	____________________

	YES	NO	DATE (s)	REMARKS
❖ Arthritis	( )	( )	________	________________
❖ Recurrent headaches / Migraine	( )	( )	________	________________
❖ Visual or hearing disorders	( )	( )	________	________________
❖ Physical Disabillity	( )	( )	________	________________
❖ Infectious diseases (e.g. measles,	( )	( )	________	________________
❖ Tuberculosis (TB), mumps, typhold)	( )	( )	________	________________
❖ Allergies to:Penicllin/ antibiotics	( )	( )	________	________________
❖ Any other substance	( )	( )	________	________________
Any other condition	( )	( )	________	________________

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	NOo	DATE(s)	REMARKS
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	REMARKS
Allergies	( )	( )	________________
Mental Disorder	( )	( )	________________
Sickle Cell Disease	( )	( )	________________
Migraine	( )	( )	________________

I certify that the above information is correct.

SIGNATURE______________________________ **DATE** ______________________________
(PARENT/ GUARDIAN)

PART B MEDICAL EXAMINATION REPORT
To be completed by 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/GUMS ______________________________

HAIR/SCALP: ______________________________

EYES: ______________ VISION: R ______________ L ______________
(Indicate whether tested with glasses or not)

EARS: ______________ HEARING ______________________________

NOSE/THROAT: ______________________________

BREASTS: ______________________________

THYROID: ______________________________

RESPIRATORY SYSTEM: ______________________________

CARDIOVASCULAR SYSTEM: ______________________________

ABDOMEN/GI SYSTEM: ______________________________

CENTRAL NERVOUS SYSTEM: ______________________________

BONES AND JOINTS: ______________________________

DEFORMITES/DISABILITIES: ______________________________

GENITO URINARY SYSTEM: ______________________________

URINANLYSIS: PROTEIN: ______________ SUGAR: ______________

OTHER INVESTIGATIONS INDICATED: ______________________________
(***Following up report to be printed***)

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:					

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