

Appendix 1
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/ LEGAL 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: _____

ANY OTHER PERSONAL DATA:

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(s)	REMARKS
❖ Asthma/ Bronchitis	()	()	-----	-----
❖ Rheumatic Fever/Rh. Heart Disease	()	()	-----	-----
❖ Congenital / other Heart Disease	()	()	-----	-----
	YES	NO	DATE(s)	REMARKS
❖ 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) () () -----
- ❖ Arthritis () () -----
- ❖ Recurrent headaches/Migraine () () -----
- ❖ Visual or hearing disorders () () -----
- ❖ Physical Disability () () -----
- ❖ Infectious diseases (e.g. measles, tuberculosis (TB), mumps, typhoid) () () -----
- ❖ Allergies to: Penicillin/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	NO	DATE(s)	REMARKS
Depression	()	()	_____	_____
Learning Disability	()	()	_____	_____
Hyperactivity (ADHD)	()	()	_____	_____
Behaviour disorder	()	()	_____	_____

Has your child experienced any of 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	()	()
Any Other Situation which may be of concern to you or the child	()	()

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 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/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: _____

DEFORMITIES/DISABILITIES: _____

GENITO URINARY SYSTEM: _____

URINANALYSIS: PROTEIN: _____ SUGAR: _____ OTHER _____

OTHER INVESTIGATIONS INDICATED: _____
(Follow up report to be provided)

Immunization History: Please indicate dates vaccines received.

Vaccine	DOSES				
	1 st	2 nd	3 rd	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**

REMARKS AND RECOMMENDATIONS: _____

PHYSICAL ACTIVITY: UNRESTRICTED ()

 AS TOLERATED ()

 LIMITED ()

IF LIMITED, GIVE 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)

NCJ REG #

DATE

APPENDIX 3

Ministry of Education and Culture/Ministry of Health
School Health Programme

CONSENT TO MEDICAL TREATMENT

Dear Parent/Guardian,

While your child/ward is at it may
(Name of School)

become necessary to treat him/her for any medical emergencies which may occur during school hours. Even though attempts will be made to contact you urgently your consent is required to treat or seek medical aid for your child should the need arise.

Kindly complete this form and return it to the school.

Thank you.

Yours sincerely,

.....
PRINCIPAL

I hereby give/ do not give my consent for
(Name of Parent/Guardian)

medical treatment to be given to -----
(Name of Child)

in the event of any such emergency arising at
(Name of School)

MY CONTACT IS :-

HOME ADDRESS: -----

WORK ADDRESS: -----

HOME PHONE NO: WORK PHONE NO:

OUR FAMILY DOCTOR IS:

NAME: -----

ADDRESS: -----

TELEPHONE NO: -----

SIGNATURE:
(Parent/Guardian)

DATE: