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 ☐

STUDENT'S ADDRESS: ____

____

NAME OF PARENT/GUARDIAN: ____
(Indicate by circling)

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?

PAST HISTORY	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	( )	( )	_________________________________
❖ Hypertension	( )	( )	_________________________________
❖ Diabetes	( )	( )	_________________________________

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: __________T/P/R____________

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: ____________________

URINANLYSIS: PROTEIN: ____________SUGAR: ____________ OTHER____________

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/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 / TREATMENT GIVEN OR RECOMMENDED: ________

____

____

____

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) (Nurse / Doctor's signature)

DATE: …………………………………………….. **DATE:** …………………………………