LIGUANEA PREPARATORY SCHOOL
15A EAST KINGS HOUSE ROAD
KINGSTON 6
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Child's Medical Report

Part A **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN**

PERSONAL DATA

CHILD'S NAME: _____

DATE OF BIRTH; _____/_____/_____AGE: _____YRS _____Months SEX: M ☐ F ☐

ADDRESS: _____

_____ TELEPHONE NO.: _____

NAME OF PARENT/GUARDIAN: _____

ADDRESS: (H) _____

_____

ADDRESS: (W) _____

_____

TELEPHONE NO: (W) _____ (H) _____ (Cell) _____

EMERGENCY CONTACT INFORMATION **(other than parent/guardian)**

NAME:_____ RELATION: _____TEL. NO: _____

ADDRESS: _____

_____

FAMILY DOCTOR/HEALTH CLINIC:_____

ADDRESS:_____

_____

TEL. 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 any of the following conditions?

PAST HISTORY	YES	NO	DATE(s)	REMARKS
❖ Asthma	( )	( )	_____	_____
❖ Bronchitis	( )	( )	_____	_____
❖ Tuberculosis (TB)	( )	( )	_____	_____
❖ Disorders of the Ears/Nose/Throat	( )	( )	_____	_____
❖ Rheumatic Fever/Rh. Heart Disease	( )	( )	_____	_____
❖ Heart Disease	( )	( )	_____	_____
❖ Epilepsy (Fits)	( )	( )	_____	_____
❖ Mental Disorders	( )	( )	_____	_____
❖ Learning Disability	( )	( )	_____	_____
❖ Physical Disability	( )	( )	_____	_____
❖ Disorders of the Kidney/bladder	( )	( )	_____	_____
❖ Disorders of Stomach/Bowels	( )	( )	_____	_____
❖ Sickle Cell Trait/Disease	( )	( )	_____	_____
❖ High Blood Pressure	( )	( )	_____	_____
❖ Diabetes Mellitus (Sugar)	( )	( )	_____	_____
❖ Leukemia/Lymphoma	( )	( )	_____	_____
❖ Typhoid	( )	( )	_____	_____
❖ Headaches	( )	( )	_____	_____
❖ Anaemia(weak blood)	( )	( )	_____	_____
❖ Fainting spells/giddiness	( )	( )	_____	_____
❖ Excess Tiredness	( )	( )	_____	_____
❖ Visual disorders	( )	( )	_____	_____
❖ Hearing disorders	( )	( )	_____	_____
❖ Hepatitis B	( )	( )	_____	_____
❖ Meningitis	( )	( )	_____	_____
❖ Allergies to Medication	( )	( )	_____	_____

List _____ _____

❖ 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): _____

FAMILY HISTORY

Has any family member been diagnosed with the following?

	YES	NO	REMARKS
❖ Asthma	( )	( )	_____
❖ Allergies	( )	( )	_____
❖ Diabetes Mellitus	( )	( )	_____
❖ Tuberculosis	( )	( )	_____
❖ Cancer/Tumours	( )	( )	_____
❖ Sickle Cell Disease	( )	( )	_____
❖ Mental Disorder	( )	( )	_____
❖ Heart disease	( )	( )	_____
❖ Migraine	( )	( )	_____
❖ High Blood Pressure	( )	( )	_____

I certify that the above information is correct.

SIGNATURE: _____ DATE: _____
(PARENT/GUARDIAN)

PART B MEDICAL EXAMINATION REPORT – To be completed by a Physician

Please give details of findings and verify immunization history

CHILD'S NAME: _____

DATE OF BIRTH: _____ Age: _____HEIGHT: _____cm WEIGHT: _____kg.

BP: _____ Urinalysis: Protein: _____ Sugar: _____

General Appearance: _____ Nutritional State: _____

Posture: _____TEETH/GUMS: _____

Skin: _____ HAIR/SCALP: _____

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

*EARS:*_____ *Nose:* _____ *Throat* _____ *HEARING:* _____

BREASTS: _____ THYROID: _____

RESPIRATORY SYSTEM: _____

CARDIOVASCULAR SYSTEM: _____

ABDOMEN/GI SYSTEM: _____

CENTRAL NERVOUS SYSTEM: _____

BONES AND JOINTS: _____DEFORMITIES/DISABILITIES: _____

GENITO URINARY SYSTEM: _____

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:					

***Immunization card to be taken to the Early Childhood Institution for the records**

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

REMARKS AND RECOMMENDATIONS:

_____

_____

_____

_____

PHYSICAL ACTIVITY: UNRESTRICTED ☐

AS TOLERATED ☐

LIMITED ☐

If limited, give reason:

_____

_____

_____

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DOCTOR'S SIGNATURE ADDRESS

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DOCTOR'S NAME (WRITTEN) MCJ REG. # DATE