VAZ PREPARATORY SCHOOL
MEDICAL REPORT FORM

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

ACADEMIC YEAR: ___________________

PERSONAL DATA

STUDENT'S NAME: ____

DATE OF BIRTH: ____/______/______ AGE: _______YRS GENDER: M ☐ F ☐
dd mm yyyy

ADDRESS: ____

____

MEDICAL/HEALTH CENTRE: ____

PHYSICIAN/PAEDIATRICIAN (FULLNAME): ______________________________________

ADDRESS: ____

TELEPHONE: ____

PARENT/GUARDIAN NAME: ____

HOME ADDRESS: ____

____

BUSINESS NAME & ADDRESS: ____

____

TELEPHONE: (W) _______________ (H) __________________ (C) ___________________

PARENT/GUARDIAN NAME: ____

HOME ADDRESS: ____

____

BUSINESS NAME & ADDRESS: ____

____

TELEPHONE: (W) ________________ (H) ___________________ (C) ____________________

EMERGENCY CONTACT INFORMATION

NAME: ______________________________ RELATIONSHIP: ______________________

ADDRESS: ____

TELEPHONE: (W) ________________ (H) ___________________ (C) ____________________

MEDICAL INFORMATION

Has your child ever been diagnosed or treated for any of the following conditions? Please respond by putting a tick (√) in the appropriate area and comment for positive responses.

CONDITION	YES	NO	COMMENTS
Asthma/Bronchitis			
Rheumatic Fever/Rh. Heart Disease			
Congenital or other Heart Disease			
Sickle Cell Trait/Disease			
Seizures (Epilepsy/Fits)			
Fainting spells/giddiness			
Anaemia (weak blood)			
Excessive tiredness			
Disorder of Ears, Nose or Throat			
Visual disorder			
Hyperglycaemic (Sugar)			
Chronic Disease (Cancer/Thyroid etc)			
Arthritis			
Recurrent headache/Migraine			
Physical Disability			
Infectious diseases (measles, mumps, chicken pox, tuberculosis, typhoid)			
Allergies to Medication: Penicillin/antibiotic or other medication			
Other Allergies			
Any other condition/s			

HAS YOUR CHILD EVER BEEN ADMITTED TO HOSPITAL OR HAD SURGERY? YES ☐ NO ☐

If yes, for what reason. ____

____

____

REGULAR MEDICATIONS TAKEN (IF ANY): ____

____

I hereby declare that the above information given is correct.

PARENT/GUARDIAN: ___________________________ ___________________________

Print Name Signature

____

Date

Part B: MEDICAL EXAMINATION REPORT

To be completed by a Physician or Peadiatrician.
Please give findings and verify immunization history.

STUDENT'S NAME: ____

DATE OF BIRTH: ____/______/______ AGE: _______YRS
dd mm yyyy

HEIGHT: ______________ cm WEIGHT: ____________ kg BP: _______________

GENERAL APPEARANCE: ____

NUTRITIONAL STATE: _____________________________ POSTURE: ______________________

SKIN: __________________________ TEETH/GUMS: ________________________________

HAIR/SCALP: ____

EYES: _____________________________ VISION: _____________________________________
(Indicate whether tested with glasses or not)

EARS: ____________________________ HEARING: ___________________________________

NOSE/THROAT: ____

RESPIRATORY SYSTEM: ____

CENTRAL NERVOUS SYTEM: ____

ABDOMEN/GI SYSTEM: ____

BONES AND JOINT: ____

DEFORMITIES/DISABILITIES: ____

URINALYSIS: PORTEIN: __________________________ SUGAR: _________________________

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					
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 reason: ____

____

____

CERTIFIED FIT FOR ADMISSION TO SCHOOL. YES ☐ NO ☐

__________________________________ __________________________________

PHYSICIAN/PAEDIATRICIAN'S SIGNATURE MCJ REG#

_______________________________________ __________________________________

CONTACT # DATE