GLENMUIR HIGH SCHOOL

MEDICAL EXAMINATION RECORD

STUDENT'S PERSONAL INFORMATION

NAME _____
LAST FIRST MIDDLE

ADDRESS _____
STREET OR DISTRICT POST OFFICE PARISH

SEX: M ☐ F ☐ **D.O. B.** ____ /_____ /_____ **AGE**:_____ **ACADEMIC YEAR** _____
DY MTH YR

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	☐	☐		
Sickle Cell Disease	☐	☐		
Seizures	☐	☐		
Fainting spells/giddiness	☐	☐		
Anaemia	☐	☐		
Disorders of the Ears, Nose, Throat	☐	☐		
Diabetes Mellitus	☐	☐		
Hypertension	☐	☐		
High Cholesterol	☐	☐		
Arthritis	☐	☐		
Recurrent headaches/Migraine	☐	☐		
Visual or hearing disorders	☐	☐		
Physical Disability	☐	☐		
Psychological disorder (e.g. post- traumatic stress disorder)	☐	☐		
Infectious diseases	☐	☐		
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 & give dates. _____

_____

_____

Is your child taking any medications? YES ☐ NO ☐

If yes, please list (with frequency and duration). _____

Menarche: YES ☐ NO ☐ N/A ☐ **If yes, LMP:**_____

Has your daughter ever experienced dysmenorrhea? YES ☐ NO ☐

If yes, please state medication prescribed for same: _____

EMOTIONAL HISTORY

HAS YOUR CHILD EVER BEEN DIAGNOSED WITH THE FOLLOWING?

PAST HISTORY	YES	NO	DATE(s)	REMARKS
Depression	☐	☐		
Learning Disability	☐	☐		
Hyperactivity (ADHD)	☐	☐		
Behaviour disorder	☐	☐		
Anxiety	☐	☐		

HAS YOUR CHILD EXPERIENCED THE FOLLOWING?

	YES	NO	REMARKS
Recent stress e.g. 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	☐	☐	
Use of any of the following substances (alcohol, cannabis (ganja), cigarettes, Crack /cocaine, inhalants (e.g., sniffing glue), other)	☐	☐	

Further Remarks :_____

_____

_____

_____

_____

FAMILY HISTORY

HAS ANYONE IN THE CHILD'S FAMILY EVER BEEN DIAGNOSED AND/OR TREATED FOR ANY OF THE FOLLOWING CONDITIONS?

PAST HISTORY	YES	NO	DATE(s)	REMARKS / RELATION TO STUDENT
Diabetes Mellitus				
Hypertension				
Heart Disease/Stroke				
Sickle Cell Disease				
Mental Illness				
Cancer				
Other, state				

_____

MEDICAL EXAMINATION

PLEASE GIVE DETAILS OF FINDINGS AND VERIFY IMMUNIZATION HISTORY

HEIGHT: _____cm WEIGHT: _____kg. BP: _____

BMI Kg/m^2):_____ BMI-FOR-AGE (use chart for interpretation): _____

(Calculate BMI: Eg. If, Wt. = 35 KG Ht. = 120 cm [1.20m] BMI = 35 ÷ [1.20mx 1.20m] = 24.3)

GENERAL APPEARANCE: _____

NUTRITIONAL STATUS: _____ POSTURE: _____

SKIN: _____TEETH/GUMS: _____

HAIR/SCALP: _____

EYES: _____ VISION: (R) _____ (L)_____

INDICATE WHETHER TESTED WITH GLASSES OR NOT: YES ☐ NO ☐

EARS: _____HEARING: _____

NOSE/THROAT: _____

BREASTS: _____

THYROID: _____

RESPIRATORY SYSTEM: _____

CARDIOVASCULAR SYSTEM: _____

ABDOMEN/GI SYSTEM: _____

CENTRAL NERVOUS SYSTEM: _____

BONES AND JOINTS: _____

GENITOURINARY SYSTEM: _____

DEFORMITIES/DISABILITIES: _____

URINALYSIS: PROTEIN: _____GLUCOSE: _____

BLOOD: _____ LEUCOCYTES: _____ OTHER: _____

IMMUNIZATION HISTORY

PLEASE INDICATE DATES VACCINES WERE RECEIVED:

	DATES ADMINISTERED					
Vaccine	**1st**	**2nd**	**3rd**	**Booster 1**	**Booster 2**	**Booster 3**
BCG						
DPT/DT						
Polio						
MMR						
Chicken Pox						
Hep B						
Hib						
Pneumococcal						
HPV						
Other:						
Other:						
Other:						

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

FULLY IMMUNIZED? YES ☐ NO ☐

OUTSTANDING DOSES?: YES ☐ NO ☐ If yes, specify: _____

ASSESSMENT

KEY FINDINGS: _____

_____

_____

_____

REFERRAL/FOLLOW UP REQUIRED: YES ☐ NO ☐

If yes, specify: _____

ADDITIONAL REMARKS & RECOMMENDATIONS: _____

_____

PHYSICAL ACTIVITY: UNRESTRICTED ☐ AS TOLERATED ☐ LIMITED ☐

If limited, state reason: _____

_____

CERTIFIED FIT FOR ADMISSION TO SCHOOL: YES ☐ NO ☐

NAME: _____ SIGNATURE:_____

DOCTOR

DATE:_____

OFFICE: _____

ADDRESS:_____

TELEPHONE NUMBER;_____

KINDLY AFFIX OFFICIAL STAMP

GLENMUIR HIGH SCHOOL
CONSENT TO MEDICAL TREATMENT

Dear Parent/ Legal Guardian,

While your child/ward is at Glenmuir High School it may become necessary to treat him/her for any health need or emergencies which may occur during school hours. In cases of emergencies, attempts will be made to contact you urgently; however, for our School Nurse or other health professional/s to administer care and or medication to your child/ward, your consent is required.

Kindly complete the consent form below and return it with the remainder of the medical.

Yours sincerely,

…….

Dr. Marsha Smalling, J.P.
Principal

AUTHORIZATION

TO BE COMPLETED BY A PARENT OR A LEGAL GUARDIAN WITH THE NURSE OR DOCTOR

I……. hereby give ☐ / do not give☐ my consent for
(NAME OF PARENT/ LEGAL GUARDIAN)

health care/ treatment to be given to …… in the event of any such
(NAME OF CHILD)

need / emergency arising at Glenmuir High School

SIGNATURE: …… **…….**
(PARENT/ LEGAL GUARDIAN) WITNESSED BY, NURSE (RN) / DOCTOR

DATE: ……..…….. ***DATE: ……..……***

OUR FAMILY DOCTOR INFORMATION:

NAME ……..……. TELEPHONENO: ……

ADDRESS ……

……

NB. Nurses/Principals - this sheet must be copied and accompany the student to health facilities, when being taken from school.