



Medical Report

To Be Checked & Completed by Parent/ Guardian:

Child's Name:		Home tel:	
Gender:		Mother mobile:	
Date of birth:		Mother work:	
Religion:		Father mobile:	
Mother's name:		Father work:	
Father's name:		Emergency contact:	

❖ Does your child take regular medication? If Yes please give details

❖ Will medication be necessary during school time? If Yes please fill in the attached consent form and return with medication.

❖ Does your child have any allergies? If Yes please give details.

❖ Does your child have any special medical problems that the school should know about, especially in case of emergency? Please give details.

CONSENT TO TREATMENT AT SCHOOL:

I consent to my child (as named above) receiving necessary medication and/ or First Aid at the school in the first instance and/ or arrangements being made, in an emergency, for my child to receive initial treatment at a clinic/ hospital of the school's choice.

Signature

Date

Physical Examination

To Be Completed by the Family Doctor:

Child's Family Name:

First Name:

	Result	Comments
Height		
Weight		Birth Weight:
Development		
Eyes: Vision (with/ without glasses)	Right: Left:	
Ears: Hearing (Audiometry)	Right: Left:	
Skin		
Mouth		
Teeth: Permanent Deciduous		
Nose		
Throat: Lymph Nodes		
Lungs		
Heart	Size: _____ Sounds: _____ Rhythm: _____ Rate: _____ Murmurs: _____	
Abdomen		
Genital		
Extremities		
Posture	Spine: _____ Feet: _____	
Reflexes		
Urine	Albumen: _____ Sugar: _____	

Immunisation/ Health History

PLEASE ATTACH IMMUNISATION RECORDS OR COMPLETE THE TABLE BELOW.

Immunisation	DATES					
	1	2	3	4	5	6
DTP: Diptheria, Tetanus, Pertussis						
DT: Diptheria, Tetanus						
Hib: Haemophilus Influenzae b						
MMR: Measles, Mumps, Rubella						
OPV: Oral Polio Vaccine						
Meningitis: (please specify which one)						
Hepatitis B						
Tuberculin Test (Heaf/Mantoux)	Positive	Negative				
BCG: TB Immunisation						
Other (please specify)						

Has your child had any of the following? If yes, please tick the appropriate boxes and give further comments below or attach a letter giving full details.

- | | | |
|--|---|--|
| <input type="checkbox"/> Pox (Varicella) | <input type="checkbox"/> Eczema | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Coordination problems | <input type="checkbox"/> Orthopaedic problems |
| <input type="checkbox"/> Chicken Mumps | <input type="checkbox"/> Hearing problems | <input type="checkbox"/> Hospitalisations |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Concentration problems | <input type="checkbox"/> Surgical procedures |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Speech difficulties | <input type="checkbox"/> Other serious illness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Other |



Recommendations for Physical Activity

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Please tick boxes and comment where appropriate

- Full Physical Activity, including swimming and gymnastics with normal supervision.

- Modified physical activity, due to reasons stated below.

- Modifications in pupil's programme or limitation:

Please attach copies of investigation reports where possible.

Address/ Contact details of Doctor:

Signature & Stamp of Doctor

Date