Medical Report

Child/Student details to be completed by parents/guardians:

Child's Full Name:		Home tel:	
Gender:	F ☐ M ☐	Mother mobile:	
Date of birth:		Mother work:	
Mother's name:		Father mobile:	
Father's name:		Father work:	
		Emergency contact: Name in Full: Relation: Mobile:	

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

NO | YES _____

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

NO | YES _____

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

NO | YES _____

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

NO | YES _____

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 (Audiomerty)	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 Poio 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.

- ❑ Pox (Varicella)
- ❑ Measles
- ❑ Chicken Mumps
- ❑ Whooping Cough
- ❑ Allergies
- ❑ Asthma
- ❑ Eczema
- ❑ Coordination problems
- ❑ Hearing problems
- ❑ Concentration problems
- ❑ Speech difficulties
- ❑ Epilepsy
- ❑ Rheumatic fever
- ❑ Orthopaedic problems
- ❑ Hospitalisations
- ❑ Surgical procedures
- ❑ Other serious illness
- ❑ Other

Recommendations for Physical Activity in School

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