THE HARBOUR ISLAND GREEN SCHOOL

FORM A:
STUDENT MEDICAL REPORT

To be completed and signed by a parent/ legal guardian:

PERSONAL DATA

STUDENT'S NAME:_____

DATE OF BIRTH:_____ AGE:____ SEX: M F

ADDRESS:_____

TELEPHONE NO:_____

NAME OF PARENT/GUARDIAN: _____

ADDRESS: (H)_____

ADDRESS: (W)_____

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

EMERGENCY #1 CONTACT INFORMATION

NAME:_____RELATIONSHIP:_____

ADDRESS: _____

TELEPHONE NO(s): _____

FAMILY DOCTOR OR HEALTH CLINIC: _____

ADDRESS: _____

TELEPHONE NO: _____

ANY OTHER PERSONAL DATA:

EMERGENCY #2 CONTACT INFORMATION

NAME:_____RELATIONSHIP:_____

ADDRESS: _____

TELEPHONE NO(s): _____

FAMILY DOCTOR OR HEALTH CLINIC: _____

ADDRESS: _____

TELEPHONE NO: _____

ANY OTHER PERSONAL DATA:

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	NO	YES	DATE(s)	REMARKS
❖ Asthma/ Bronchitis	( )	( )	----------	----------
❖ Rheumatic Fever/Rh. Heart Disease	( )	( )	----------	----------
❖ Congenital / other Heart Disease	( )	( )	----------	----------_
❖ Sickle Cell Trait/Disease	( )	( )	----------	----------
❖ Seizures (Epilepsy /Fits)	( )	( )	----------	----------
❖ Fainting spells/dizziness	( )	( )	----------	----------
❖ Anaemia(weak blood)	( )	( )	----------	----------
❖ Excess Tiredness	( )	( )	----------	----------
❖ Disorders of the Ears, Nose, Throat	( )	( )	----------	----------
❖ Diabetes Mellitus (Sugar)	( )	( )	----------	----------
❖ Chronic Disease(eg Cancer/Thyroid)	( )	( )	----------	----------
❖ Arthritis	( )	( )	----------	----------
❖ Recurrent headaches/Migraine	( )	( )	----------	----------
❖ Visual or hearing disorders	( )	( )	----------	----------
❖ Physical Disability	( )	( )	----------	----------
❖ Infectious diseases (e.g. measles, tuberculosis (TB), mumps, typhoid)	( )	( )	----------	----------
❖ 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. _____

_____

REGULAR MEDICATIONS TAKEN (IF ANY):_____

_____

EMOTIONAL HISTORY

Has your child ever been diagnosed with the following?

	YES	NO	DATE(s)	REMARKS
Depression	( )	( )	_____	_____
Learning Disability	( )	( )	_____	_____
Hyperactivity (ADHD)	( )	( )	_____	_____
Behaviour disorder	( )	( )	_____	_____

Has your child experienced any of the following?	YES	NO
Recent stress eg. 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	( )	( )
Any Other Situation which may be of concern to you or the child	( )	( )

Explain:_____

_____

_____

FAMILY HISTORY

Has any family member been diagnosed with the following?

	YES	NO	REMARKS
❖ Allergies	( )	( )	_____
❖ Mental Disorder	( )	( )	_____
❖ Sickle Cell Disease	( )	( )	_____
❖ Migraine	( )	( )	_____

I certify that the above information is correct.

_____ _____

Parent/Guardian Printed Signature Date