SCHOOL MEDICAL FORM

PERSONAL INFORMATION

Surname	Name:	Date of Birth: Sex: M/F
Home Address:	**Parents Information** **Father's name: _____** **Mother's name: _____**	
Origin :	**Contact Information :**	
School :	**Class :**	

CONSENT

Student Full Name_____Signature_____

DATE _____

UNDER 18 CONSENT BY PARENT OR GUARDIAN

NAME_____SIGNATURE_____

DATE_____

SCHOOL MEDICAL FORM

MEDICAL HISTORY QUESTIONS	RESPONSE (✓)	ADDITIONAL INFORMATION FOR "YES" ONLY
1. Do you or any of your family members suffer from Tuberculosis,	☐YES ☐NO	
2. Do you suffer from weight loss, spitting of blood, night sweats or a persistent cough?	☐YES ☐NO	
3. Do you suffer from Asthma, breathlessness, any heart, kidney, lung disease or diabetes?	☐YES ☐NO	
4. Epilepsy, fits or fainting		
5. Discharge from ears or hearing problems?	☐YES ☐NO	
6. Dermatitis, any skin eruption or sun cancer?	☐YES ☐NO	
7. Have you ever had a back injury or broken bones	☐YES ☐NO	
8. Have you ever had any operation	☐YES ☐NO	
9. Are you undergoing treatment or taking any medication at the moment?	☐YES ☐NO	
10. Do you suffer from severe headaches or migraines?	☐YES ☐NO	
11. Females: do you suffer from painful periods?	☐YES ☐NO	

MEDICAL EXAMINER REPORT

	MEDICAL	RESULTS
1.	General impression: any jaundice, pallor or other concern?	
2.	Height and Weight.	Height (without shoe) _____cm Weight _____ kg
3.	Throat, Ears, any hearing problems?	
	Teeth and oral cavity	
	Lungs, is chest x-ray required?	
	Abdomen soft no masses or enlarged spleen?	
4.	Are there any enlarged glands, sores, ulcers	
5.	Is there any visual defect or disease of the eyes? In all cases of visual acuity, as indicated by test types of each eye should be indicated.	Visual Acuity – Without Glasses – Rt _____ Lt _____ With Glasses – Rt _____ Lt _____ Colour Vision: -
6.	Does the candidate suffer from hernias ?	
7.	Are posture, back and the musculoskeletal system normal?	
8.	Urinalysis:	
9.	Are there any other health conditions which is advisable should be mentioned? If so give details.	
10.	Chest X-Ray by Medical Officer(Physician) or TB Control (if indicated)	

Was the medical examination satisfactory? ☐YES ☐NO

Is a referral or review needed ☐YES ☐NO

Referred to: _____