**MEADOWBROOK HIGH SCHOOL**

# MEDICAL REPORT

**TO BE COMPLETED AND SIGNED BY A MEDICAL DOCTOR**

You are requested to take your child's immunization records and supply the information required.

NAME OF STUDENT: _____
FIRST M/INITIAL LAST

Date of Birth: _____/_____/_____ AGE: _____ ACADEMIC YEAR: ……..
(DD/ MM / YY)

| | MOTHER | FATHER |
|---|---|---|
| Name: | …… | ……..…… |
| Home Address: | …… | …… |
| | …… | …… |
| Phone: | …… | …… |
| Occupation: | …… | ……..…… |
| Employed at: | ……. | ……..…..…… |
| Work Phone: | ……. | …… |

PERSONAL DOCTOR OR HEALTH CLINIC : ……..…..

ADDRESS : ……Phone: ……

**MEDICAL HISTORY**

Please tick any condition that exists in your family

| | YES | NO | NOTES |
|---|---|---|---|
| 1. Allergies | [ ] | [ ] | ……. |
| 2. Sickle Cell | [ ] | [ ] | ……. |
| 3. Diabetes | [ ] | [ ] | ……. |
| 4. High Blood Pressure | [ ] | [ ] | ……. |
| 5. Tuberculosis | [ ] | [ ] | ……. |

OTHER : ……

Has the student ever been treated for?

| | YES | NO | NOTES |
|---|---|---|---|
| 1. Fits (SEIZURE/EPILEPSY) | [ ] | [ ] | …….. |
| 2. Rheumatic Fever | [ ] | [ ] | …….. |
| 3. Diabetes | [ ] | [ ] | …….. |
| 4. Major Accidents | [ ] | [ ] | ……. |
| 5. Surgical Operations | [ ] | [ ] | ……. |
| 6. Mental Condition | [ ] | [ ] | ……. |

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**MEDICAL EXAMINATION REPORT**

HEIGHT: ……..cm WEIGHT: ……kg BP: ……..

MENARCHE: YES [ ] NO [ ] IF YES, LMP : ……..

BREASTS: ……..

GENERAL APPEARANCE: ……..…..

NUTRITIONAL STATE: …….. POSTURE: …..…….....…

DEFORMITIES/DISABILITIES: ……..…

SKIN: …….. TEETH/GUMS: ……..…...

HAIR/SCALP: ……..……...……

EYES: …….. VISION: R …….. L …….. GLASSES: ……

EARS: ……..…… HEARING: ……..……..

NOSE/THROAT: ……

THYROIDS: ……..

RESPIRATORY SYSTEM: ……..

CARDIOVASCULAR SYSTEM: ……

ABDOMEN/ GI SYSTEM: ……..

CENTRAL NERVOUS SYSTEM: ……..…

BONES AND JOINTS: ……..

URINOGENITAL SYSTEM: ……..

URINE ANALYSIS: SUGAR …….. PROTEIN: ……..

**IMMUNIZATION STATUS:** RECORD/S SEEN: YES [ ] NO [ ]

FULLY IMMUNIZED : YES [ ] NO [ ]

REMARKS/RECOMMENDATIONS: ……

……..

**PARTICIPATION IN PHYSICAL ACTIVITY :**

UNRESTRICTED [ ] AS TOLERABLE [ ] LIMITED [ ] NONE [ ]

REMARKS IF LIMITED OR NONE : ……

……..

**CERTIFIED FIT FOR ADMISSION TO SCHOOL: YES [ ] NO [ ]**

**……..** DATE EXAMINED **: ……..**

DOCTOR'S NAME (WRITTEN)

**……..……..**

DOCTOR'S SIGNATURE

STAMP

MCJ REG. # : **……..……..**