Little Scholars Academy – Child's Medical Report

Part A TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN

NAME OF EARLY CHILDHOOD INSTITUTION: **Little Scholars Academy**

PERSONAL DATA

CHILD'S NAME: ____

DATE OF BIRTH: ___/___/______ Age: ______ YRS _____ Months SEX: M☐ F ☐

ADDRESS:

____

____ TELEPHONE NO.: __________________

NAME OF PARENT/GUARDIAN:

____

ADDRESS: (H)

____

ADDRESS: (W) ____

TELEPHONE NO: (W) ____________________ (H) __________________ (Cell) ________________

EMERGENCY CONTACT INFORMATION (other than parent/guardian)

NAME: ___________________________________ RELATION: __________ TEL NO: ____________

ADDRESS: ____

FAMILY DOCTOR/HEALTH CLINIC: ________________________________ ADDRESS: _____________

____ TEL. NO: _______________________

MEDICAL HISTORY

Please respond by putting a tick (√) under the appropriate column, and record dates of last treatment, as well as remarks for positive responses.

Has your child ever been diagnosed or treated for any of the following conditions?

PAST HISTORY	YES	NO	DATE(s)	REMARKS
❖ Asthma	( )	( )		
❖ Bronchitis	( )	( )		
❖ Tuberculosis (TB)	( )	( )		
❖ Disorders of the Ears/Nose/Throat	( )	( )		
❖ Rheumatic Fever/Rh. Heart Disease	( )	( )		
❖ Heart Diseases	( )	( )		
❖ Epilepsy (Fits)	( )	( )		
❖ Mental Disorders	( )	( )		
❖ Learning Disability	( )	( )		
❖ Physical Disability	( )	( )		
❖ Disorders of the Kidney/Bladder	( )	( )		
❖ Disorders of the Stomach/Bowels	( )	( )		
❖ Sickle Cell Trait/Disease	( )	( )		
❖ High Blood Pressure	( )	( )		
❖ Diabetes Mellitus (Sugar)	( )	( )		
❖ Leukaemia/Lymphoma	( )	( )		
❖ Typhoid	( )	( )		
❖ Headaches	( )	( )		
❖ Anaemia (weak blood)	( )	( )		

- ❖ Fainting spells/giddiness ( ) ( )
- ❖ Excess Tiredness ( ) ( )
- ❖ Visual disorders ( ) ( )
- ❖ Hearing disorders ( ) ( )
- ❖ Hepatitis B ( ) ( )
- ❖ Meningitis ( ) ( )
- ❖ Allergies to Medication ( ) ( )
- ❖ Other conditions ( ) ( )

HAS YOUR CHILD EVER BEEN ADMITTED TO HOSPITAL OR HAD SURGERY? Yes ☐ No☐

If yes, please explain the purpose.

____

____

REGULAR MEDICATIONS TAKEN (IF ANY): ____

FAMILY HISTORY

Has any family member been diagnosed with the following?

	YES	NO	REMARKS
❖ Asthma	( )	( )	______________________________
❖ Allergies	( )	( )	______________________________
❖ Diabetes Mellitus	( )	( )	______________________________
❖ Tuberculosis	( )	( )	______________________________
❖ Cancer/Tumours	( )	( )	______________________________
❖ Sickle Cell Disease	( )	( )	______________________________
❖ Mental Disorder	( )	( )	______________________________
❖ Heart Disease	( )	( )	______________________________
❖ Migraine	( )	( )	______________________________
❖ High Blood Pressure	( )	( )	______________________________

I certify that the above information is correct.

SIGNATURE: __________________________ DATE: _____________________

(PARENT/GUARDIAN)

MEDICAL EXAMINATION REPORT – To be completed by a Physician

Please give details of findings, and verify immunization history.

CHILD'S NAME: ____

DATE OF BIRTH: ______________________ Age: ______ HEIGHT: ________ cm WEIGHT: _____ kg.

BP: __________________ Urinalysis: Protein: __________________ Sugar: _____________

General Appearance: _____________________________ Nutritional State: _______________

Posture: ____________________________________ TEETH/GUMS: _________________