



# JESUIT MEMORIAL COLLEGE

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## STUDENT HEALTH FORM 2

(TO BE COMPLETED BY A CERTIFIED MEDICAL PRACTITIONER)

### STUDENT'S INFORMATION

NAME: \_\_\_\_\_  
*Surname* *First Name* *Other Name(s)*

DATE OF BIRTH (*dd/mm/yyyy*) \_\_\_\_\_ GENDER: \_\_\_\_\_

1. Does this child have a health condition that may require emergency action while in school (e.g. seizure, asthmatic attack, insect sting allergy, bleeding problem, diabetes, heart problem, etc.)?

Yes  No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Is this child on a long-term technological assistance? Yes  No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Please indicate the results of your examination in the underlisted areas:

### RESULTS

Vision:	_____	_____
Hearing:	_____	_____
Speech/Language:	_____	_____
Development:	_____	_____
Attention Deficit/Hyperactivity:	_____	_____

4. IMMUNIZATION

- a. **DPT:** \_\_\_\_\_ **POLIO:** \_\_\_\_\_ **MMR:** \_\_\_\_\_ Others: \_\_\_\_\_
- b. **CHICKEN POX:** Date of immunization: \_\_\_\_\_ Booster Due Date: \_\_\_\_\_
- c. **HEPATITIS B:** 1<sup>st</sup> Dose: \_\_\_\_\_ 2<sup>nd</sup> Dose: \_\_\_\_\_ 3<sup>rd</sup> Dose: \_\_\_\_\_
- d. **TETANUS:** Date of immunization: \_\_\_\_\_ Booster Due Date: \_\_\_\_\_
- e. **YELLOW FEVER:** Date of immunization: \_\_\_\_\_ Due Date of Next Dose: \_\_\_\_\_
- f. **TYPHOID:** Date of immunization: \_\_\_\_\_ Booster Due Date: \_\_\_\_\_
- g. **CEREBRO-SPINAL MENINGITIS:** Date of immunization: \_\_\_\_\_  
Due Date of Next Dose: \_\_\_\_\_

5. **Tuberculin Test:** Positive: \_\_\_\_\_ Negative: \_\_\_\_\_

6. Should there be any restriction of physical activity while in school? Yes  No

If yes, please specify nature and duration of restriction: \_\_\_\_\_

7. **EYE TEST:** Date: \_\_\_\_\_ Were eyeglasses recommended? Yes  No

8. **TEETH:** Date of last visit to dentist: \_\_\_\_\_  
Were dental braces recommended? Yes  No

9. ALLERGY TO MEDICATION

- a. Allergic to Mefloquine/Quinine? Yes  No   
Alternative Medicine Used: \_\_\_\_\_
- b. Allergic to Sulphurnamide? Yes  No   
Alternative Medicine Used: \_\_\_\_\_
- c. Others (*Please specify*): \_\_\_\_\_  
Alternative Medicine Used: \_\_\_\_\_

10. **SKIN:** Please list all skin problems/complaints/allergies: \_\_\_\_\_

Treatment (*if applicable*): \_\_\_\_\_

11. **BLOOD:** Genotype: \_\_\_\_\_ Blood Group: \_\_\_\_\_  
HBsAg: \_\_\_\_\_ G6PD: \_\_\_\_\_

12. **SICKLE CELL ANAEMIA?** Yes  No

If yes, please give all necessary details, including history and treatment (on a separate sheet).

13. **EPILEPSY?** Yes  No

14. **CHEST X-RAY:** Please present a recent X-ray of skeletal framework Ap & Lateral (with report).

15. In the table below, please tick all that apply:

	YES	NO	DETAILS <i>(if any)</i>
Anaemia			
Arthritis			
Bladder problem/injury			
Convulsion/seizure			
Ear problem			
Fainting spell			
Concussion			
Kidney problem/injury			
Nose bleeding			
Tuberculosis			
Ulcer			
Whooping cough			

**The parents/guardians of any child with a cardio-vascular ailment, sickle cell disease and/or epilepsy are expected to request for a meeting with the school nurse for plans for continued care of the child.**

16. Please list all **SURGICAL OPERATIONS** with dates:

- a. \_\_\_\_\_
- b. \_\_\_\_\_
- c. \_\_\_\_\_
- d. \_\_\_\_\_
- e. \_\_\_\_\_

**INFORMATION OF MEDICAL PRACTITIONER**

PLEASE USE CAPITAL LETTER THROUGHOUT

NAME: \_\_\_\_\_  
*Surname* *First Name* *Other Name(s)*

JOB TITLE/DESIGNATION: \_\_\_\_\_

OFFICE ADDRESS: \_\_\_\_\_  
 \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

PHONE NUMBER(S): \_\_\_\_\_

SIGNATURE AND STAMP/SEAL: \_\_\_\_\_

DATE: \_\_\_\_\_