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:** 1st Dose: _____ 2nd Dose: _____ 3rd 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 (*if any*)
Anaemia			
Arthritis			
Bladder problem/injury			
Convulsion/seizure			
Ear problem			
Fainting spell			
Concussion			
Kidney problem/injury			
Nose bleeding			
Tuberculosis			
Ulcer			
Whooping cough			

The parents 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: _____