JESUIT MEMORIAL COLLEGE

Elikpokwu-Odu Road, Mbodo Aluu,
P. O. Box 18095, Port Harcourt, Rivers State, Nigeria

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: _________________