Ministry of Youth and Culture/Ministry of Health

School Health Programme

Consent to Medical Treatment

Dear Parent/Guardian,

While your child/ward is at **Spanish Town High School**, it may become necessary to treat him/her for medical emergency which may occur during school hours.

Attempts will be made to contact you urgently however your consent is necessary to treat or seek further health care should the need arise.

Kindly complete this form and return it to the school.

Sincerely Yours,
Dr. Ventley A. Brown
PRINCIPAL

I …… hereby refuse/give consent for treatment to be given to ……..in the event of any medical emergency arising at Spanish Town High School.

CONTACT INFORMATION

ADDRESS	**TELEPHONE**
HOME …….	……
……..	……
WORK …….	……
…….	……
FAMILY DOCTOR …….	……
…….	……

SIGNATURE: …… **DATE:** ……...

(PARENT/GUARDIAN)

Ministry of Youth and Culture/Ministry of Health

School Health Programme

MEDICAL HISTORY REPORT

ONE STAMPED PASSPORT SIZED PHOTO

PART A **TO BE COMPLETED BY PARENT/GUARDIAN**

NAME OF SCHOOL ……...

ACADEMIC YEAR …….

STUDENT'S NAME ……...

DATE OF BIRTH ……. AGE …….. SEX: ……

ADDRESS ……...

NAME OF PARENT /GUARDIAN ……

ADDRESS ……...

TELEPHONE: **HOME** ……... **WORK** …….. **CELL** ……..

OTHER EMERGENCY CONTACT INFORMATION

NAME …… RELATIONSHIP……

ADDRESS ……...

TELEPHONE: **HOME** ……... **WORK** …….. **CELL** ……..

FAMILY DOCTOR/HEALTH CLINIC ……..

ADDRESS ……

PAST MEDICAL HISTORY

HAS YOUR CHILD EXPERIENCED ANY OF THE FOLLOWING?	**YES**	**NO**	**REMARKS**
RECENT STRESS (eg. DEATH/MIGRATION OF LOVED ONES)	( )	( )	……
DIFFICULTY MAKING FRIENDS	( )	( )	……
DIFFICULTY CONCENTRATING IN CLASS	( )	( )	……
HISTORY OF FIGHTING /HURTING OTHERS	( )	( )	……

HAS HE/SHE BEEN DIAGNOSED OR TREATED FOR ANY OF THE FOLLOWING?

❖ ASTHMA/BRONCHITIS	( )	( )	……
❖ RHEUMATICFEVER / RHEUMATIC HEART DISEASE	( )	( )	……
❖ HEART DISEASE	( )	( )	……

❖ SICKLE CELL DISEASE/TRAIT	( )	( )	……
❖ SEIZURE (EPILEPSY/FITS)	( )	( )	……
❖ ANAEMIA (WEAK BLOOD)	( )	( )	……
❖ FAINTING SPELLS/GIDDINESS	( )	( )	……
❖ DIABETES (SUGAR)	( )	( )	……
❖ CHRONIC DISEASE (THYROID/CANCER/PRESSURE)	( )	( )	……
❖ ARTHRITIS	( )	( )	……
❖ RECURRENT/MIGRAINE HEADACHES	( )	( )	……
❖ VISUAL/HEARING DISORDER	( )	( )	……
❖ PHYSICAL DISABILITY	( )	( )	……
❖ INFECTIOUS DISEASE (TB/MUMPS/MEASLES etc.)	( )	( )	……
❖ ALLERGY (e.g. PENICILLIN, etc.)	( )	( )	……
❖ OTHER MEDICAL PROBLEM	( )	( )	……

EMOTIONAL HISTORY

HAS HE /SHE BEEN DIAGNOSED WITH ANY OF THE FOLLOWING?

❖ DEPRESSION	( )	( )	……
❖ HYPERACTIVITY (ADHD)	( )	( )	……
❖ LEARNING DISABILITY	( )	( )	……
❖ BEHAVIOUR DISORDER	( )	( )	……

HAS YOUR CHILD/WARD EVER BEEN ADMITTED TO HOSPITAL OR HAD SURGERY?

( ) ( )

IF YES, EXPLAIN ……

REGULAR MEDICATION (IF ANY) …….

FAMILY HISTORY

HAS ANY FAMILY MEMBER BEEN DIAGNOSED WITH…?

- ❖ ALLERGIES
- ❖ MENTAL ILLNESS
- ❖ SICKLE CELL DISEASE
- ❖ MIGRAINE
- ❖ HYPERTENSION (PRESSURE)
- ❖ DIABETES (SUGAR)
- ❖ OTHER

I CERTIFY THAT THE ABOVE INFORMATION GIVEN IS CORRECT

SIGNATURE: …… **DATE:** ……...

(PARENT/GUARDIAN)

Ministry of Youth and Culture/Ministry of Health

School Health Programme

MEDICAL HISTORY REPORT

PART B **MEDICAL EXAMINATION REPORT**

STUDENT'S NAME: …… D.O.B. …….. SEX ……

Height …… cm; Weight …… kg; BP …… mm/hg; LMP …… Pulse ……..…... bpm

General appearance ……

Nutrition …… Oral …….. Skin ……..

Eyes ……. (rt) ……..(lt) ……. ENT……

Examination of systems:

Respiratory ……

Cardiovascular ……..

Gastro-intestinal ……

Genito-urinary …… Urine: Glucose …….. Albumen ……

Nervous (central & peripheral) …….

Musculo-skeletal ……...

Endocrine (Thyroid)……..

Immunization status: (Please see copy) ……

Physical Activity: RESTRICTED ( ) AS TOLERATED ( ) UNLIMITED ( )

IMPRESSION ……...

……

Treatment: …….

Referral: ……

Certified Fit for Admission to School: yes ( ) no ( )

…….
Doctor's Signature

(Stamp)

……
Doctor's Name

Date: ……..

	DOSES				
VACCINE	1st	2nd	3rd	Booster 1	Booster 2
BCG					
DPT/DT					
POLIO					
MMR					
CHICKEN POX					
HEP.B					
HIB					
PNEUMOVAX					
OTHER					
OTHER					

PLEASE PROVIDE A COPY OF THE IMMUNIZATION CARD FOR THE SCHOOL RECORDS

COPY ATTACHED Yes ☐ No ☐