

Ministry of Youth and Culture/Ministry of Health
School Health Programme
Consent to Medical Treatment

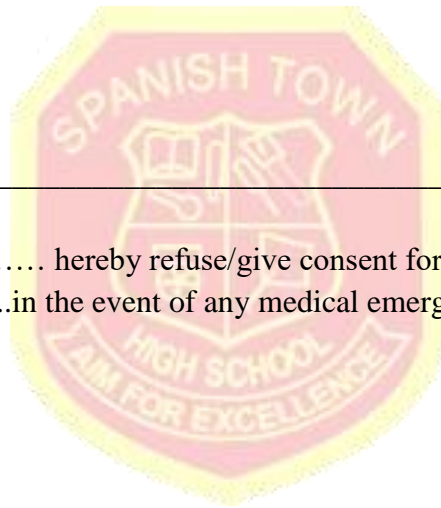
Dear Parent/Guardian,

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:
(PARENT/GUARDIAN)

DATE:

- ❖ 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:
(PARENT/GUARDIAN)

DATE:

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 ()

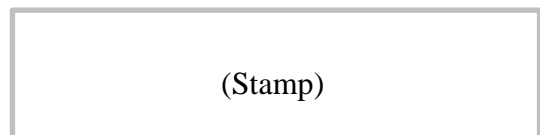
IMPRESSION

Treatment:

Referral:

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

.....
Doctor's Signature



.....
Doctor's Name

Date:

VACCINE	DOSES				
	1 st	2 nd	3 rd	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

