D+S

ST. SAVIO JUNIOR SCHOOL – KISUBI.

MEDICAL EXAMINATION REPORT.

PART ONE: TO BE FILLED BY PARENT / GUARDIAN.

1. NAME OF PUPIL: _____
2. AGE: _____ CLASS: _____YEAR:_____
3. PARENT / GUARDIAN'S NAME: _____
4. CONTACT ADRESS_____ PHONE: _____

   LOCATION: TOWN/ VILLAGE: _____ STREET_____
5. FAMILY HISTORY: IS THERE A HISTORY OF: **(YES/NO)**

   I. HEART DISEASE_____

   II. SICKLE CELL DISEASE_____

   III. CHRONIC CHEST INFECTION: i.e. ASTHMA_____

   IV. MENTAL ILLINESS/ FITS/ EPILEPSY:_____

   V. ANY OTHER FAMILY DISEASE: _____

   IF YES WHICH:_____

PART TWO (TO BE FILLED BY A QUALIFIED MEDICAL DOCTOR)

1. WEIGHT: _____ HEIGHT:_____

2. HISTORY OF PAST MEDICAL ILLINESS AND TREATMENT GIVEN:

   _____

   _____

   _____

3. HOSPITALISATION IN PAST, REASON:

   _____

4. IS THE CHILD ON ANY TREATMENT FOR A CHRONIC DISEASE?_____

   IF SO FOR WHAT? _____

   WHAT IS THE TREATMENT, THE DOSAGE AND FOR HOW LONG?

   _____

5. IS THE CHILD PREDISPOSED TO ANY PROBLEM? _____

   IF YES WHAT? _____

6. GENERAL APPEARANCE: _____

7. EYES: **CONJUCIVA**

   L: _____ R: _____

   VISUAL ACUITY:

   L:_____R: _____

   JAUNDICE:_____

8. EARS: (ANY SIGN OF DEAFNESS)_____

L:_____R:_____

9. THROAT: _____

10. SKIN: _____

11. CVS: P/S_____

BP:_____

H/S_____

12. RESPIRATORY SYSTEM: _____

13. ABDOMEN (**If any organ palpable**)_____

14. CNS:_____

ANY VISIBLE DEFORMITIES: _____

15. **LABARATORY INVESTIGATIONS:**

(a) **BLOOD** (I) HB_____ (II)B/S_____

WIDAL_____ VDRL_____

SCT_____

(b) **URINE PROTEINS:** _____ SUGAR_____

MICROSCOPY:_____

(C) **STOOL:** _____

16. I HAVE EXAMINED THIS CHILD AND CONSIDER THAT THE FOLLOWING SHOULD BE DONE BEFORE JOINING THE SCHOOL.

_____

_____

_____

17. I HAVE EXAMINED THIS CHILD AND CONSIDER THAT THE FOLLOWING SHOULD BE DONE AT THE SCHOOL. (**SOON ON ARRIVAL OR OTHERWISE**)

_____

_____

18. OTHER COMMENTS.

_____

_____

_____

DOCTOR'S NAME: _____

QUALIFICATION: _____

ADRESS:/TELEPHONE :_____

SIGNATURE AND STAMP: _____