HOLY CHILD CATHOLIC SECONDARY SCHOOL, ADO-EKITI.

MEDICAL REPORT FORM

(This form should be completed by all new students of the school.)

(A) PERSONAL DATA (To be filled by the student)

NAME:…………………………………………………………………………………

AGE:………………. SEX:………….. DATE OF BIRTH:……………………..

PLACE OF BIRTH:………………………. AGE AT LAST BIRTHDAY…………..

TOWN:…………………………………… LGA:……………………………………

STATE:…………………………………… NATIONALITY:………………………

MEDICAL HISTORY OF THE STUDENT (To be completed by the Parents)

(i) Does your child have any childhood illness? Yes/No

If yes state the nature of illness……………………………………………...........................

……………………………………………………………………………………………..

(ii) Has He/She a known Asthmatic Patient? Yes / No

If yes when was it diagnosed………………………………………………………………

When does He/She have last attack…………………………………………………..

(iii) Has He/She a known sickler? Yes / No

(iv) Any previous admission into Hospital? Yes / No

If yes state the nature of illness:……………………………………………………………

……………………………………………………………………………………………...

(v) Does He/She on any drug to be taken regularly? Yes / No

If yes state the type(s)……………………………………………………………………

(vi) Has He/She been transfused with blood before? Yes / No

If yes when…………………………………………………………………………………

(vii) Does He/She reacts to any drug or food? Yes / No

If yes state the nature……………………………………………………………………….

(viii) Has He/She been operated upon before? Yes / No

If yes state the nature of operation………………………………………………………….

(ix) Did your child receive any immunization?

Tick appropriate

(a)	BCG	Yes / No
(b)	Polio Virus Vaccine	Yes / No
(c)	Diphtheria, Pertusis, Tetanus	Yes / No
(d)	Measles	Yes / No
(e)	Yellow Fever	Yes / No
(f)	Meningitis	Yes / No

(x) Indicate any additional information about your ward that can help to look after Him/Her medically.

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…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………

(c) **MEDICAL HISTORY AND PHYSICAL EXAMINATION**
(To be completed by the Medical Officer)

(a) GENERAL EXAMINATION

Eyes	Normal / Abnormal
Nose	Normal / Abnormal
Ears	Normal / Abnormal
Gail	Normal / Abnormal

(b) VISUAL ACUITY

Right Eye	Without glasses
	With glasses
Left Eye	Without glasses
	With glasses

(c) CARDIO VASCULAR SYSTEM EXAMINATION

BP………………………………….. Pulse rate ……………………………………….
Chest Examination……………………….……………………………………………..
(*Comment*)
Abnormal Examination Hermia / No Hermia

(d) RESULTS OF INVESTIGATION

Blood group………………………………	Genotype……………………………….…
Stool Microscopy…………………………	Urinalysis………………………...……
CXR………………………………………	PCV……………………………………….
Hepatitis B & C …………………………	HIV………………………………………..

(e) Medical Officer's Comments

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