NAZ
Children's Centre

APPENDIX II

Early Childhood Institution - Child's Medical Report

PART A: TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN

Name Of Early Childhood Institution: _____

PERSONAL DATA

Child's Name: _____

Date Of Birth: (m/d/yy) ___/____/____ Age: Years _____ Months _____ Sex: ☐ M ☐ F

Address: _____

Telephone Number: _____

Name of Parent/Guardian: _____

Home Address for Parent/Guardian: _____

_____

Work Address for Parent/Guardian: _____

_____

Phone Numbers: Work _____ Home _____ Cell _____

EMERGENCY CONTACT INFORMATION (OTHER THAN PARENT/GUARDIAN)

Name: _____ Relation: _____

Phone Number: _____ Address: _____

FAMILY DOCTOR/HEALTH CLINIC:

Phone Number: _____ Address: _____

MEDICAL HISTORY

Please respond by putting a tick (a) under the appropriate column and record dates of last treatment and remarks for positive responses.

Has your child ever been diagnosed or treated for any of the following conditions?

PAST HISTORY	YES	NO	DATE(s)	REMARKS
• Asthma	( )	( )		
• Bronchitis	( )	( )		
• Tuberculosis (TB)	( )	( )		
• Disorders of the Ears/Nose/Throat	( )	( )		
• Rheumatic Fever/Rh. Heart Disease	( )	( )		
• Heart Disease	( )	( )		
• Epilepsy (Fits)	( )	( )		
• Mental Disorders	( )	( )		
• Learning Disability	( )	( )		
• Physical Disability	( )	( )		
• Disorders of the Kidney/bladder	( )	( )		
• Disorders of Stomach/Bowels	( )	( )		
• Sickle Cell Trait/Disease	( )	( )		
• High Blood Pressure	( )	( )		
• Diabetes Mellitus (Sugar)	( )	( )		
• Leukemia/Lymphoma	( )	( )		
• Typhoid	( )	( )		
• Headaches	( )	( )		
• Anaemia(weak blood)	( )	( )		
• Fainting spells/giddiness	( )	( )		
• Excess Tiredness	( )	( )		
• Visual disorders	( )	( )		
• Hearing disorders	( )	( )		
• Hepatitis B	( )	( )		
• Meningitis	( )	( )		
• Allergies to Medication	( )	( )		
• Other Condition	( )	( )		

Has Your Child Ever Been Admitted To Hospital Or Had Surgery? Yes No

If yes, please explain for what reason:_____

_____

Regular Medications Taken (If Any): _____

_____

FAMILY HISTORY

Has any family member been diagnosed with the following?

	YES	NO	REMARKS
• Asthma	( )	( )	_____
• Allergies	( )	( )	_____
• Diabetes Mellitus	( )	( )	_____
• Tuberculosis	( )	( )	_____
• Cancer/Tumours	( )	( )	_____
• Sickle Cell Disease	( )	( )	_____
• Mental Disorder	( )	( )	_____
• Heart disease	( )	( )	_____
• Migraine	( )	( )	_____
• High Blood Pressure	( )	( )	_____

I certify that the above information is correct.

Parent/Guardian Signature:_____ Date: _____

PART B: MEDICAL EXAMINATION REPORT – TO BE COMPLETED BY A PHYSICIAN

PLEASE GIVE DETAILS OF FINDINGS AND VERIFY IMMUNIZATION HISTORY

Child's Name: _____

Date Of Birth: (m/d/yy) ___/____/____ Age: _____ Height: _____cm Weight: _____kg

Blood Pressure:_____ Urinalysis: Protein_____ Sugar:_____

General Appearance: _____ Nutritional State:_____

Posture:_____ Teeth/Gums: _____

Skin:_____ Hair/Scalp:_____

Eyes: ☐ Tested with glasses ☐ Tested without glasses):

Vision: R_____ L_____

Ears:_____ Nose:_____ Throat:_____ Hearing:_____

Breasts:_____ Thyroid:_____

Respiratory System:_____

Cardiovascular System: _____

Abdomen/Gi System: _____

Central Nervous System: _____

Bones and Joints: _____Deformities/Disabilities: _____

Genito Urinary System: _____

IMMUNIZATION HISTORY: PLEASE INDICATE DATES VACCINES RECEIVED.

	DOSES				
Vaccine	**1st**	**2nd**	**3rd**	**Booster 1**	**Booster 2**
BCG					
DPT/DT					
Polio					
MMR					
Chicken Pox					
Hep. B					
Hib					
Pneumovax					
Other:					
Other					

***Immunization card to be taken to the Early Childhood Institution for the records**

Investigations Indicated: (Follow Up Report To Be Provided) _____

_____

REMARKS AND RECOMMENDATIONS:

_____

_____

Physical Activity:
☐ Unrestricted ☐ As Tolerated ☐ Limited

If Limited, Give Reason: _____

_____

Doctor's Signature:_____

Address:_____

Doctor's Name (Written): _____

Mcj Reg. #:_____ Date:_____