MEDICAL FITNESS FORM

PART A: BIODATA (To be completed by parents)

Name of Student: ……

MEDICAL HISTORY

Does your ward have any of the following conditions? (Tick appropriate option)

- ☐ Sickle cell
- ☐ Asthma
- ☐ Breathing problems
- ☐ Skin disorder
- ☐ Hearing problems
- ☐ Sight problems
- ☐ Speech problems
- ☐ Behavioural problems
- ☐ Developmental problems
- ☐ Dental problems
- ☐ Allergies (food, insect, season, etc.)
- ☐ Attention Deficit Disorder (ADHD)
- ☐ Heart disease
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Diabetes
- ☐ Incontinence
- ☐ Epilepsy/Seizures
- ☐ Mental illness
- ☐ Orthopedic condition
- ☐ Drug addiction

If yes to allergies, kindly give details and treatment required:

……

……

Others (Please describe any other health related information about your child)

……

……

Is your ward presently on any medication, prescription or OTC? Yes…… No…….
If yes, kindly give details including names of medication and dosages.

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……

☐ Tick if you want to discuss any other confidential information with the school nurse.

In case of any medical emergency, give the details of the person(s) to be contacted:
Name: ……
Address: ……

……

Telephone: …… E- mail: ……

PART B: MEDICAL CONSENT FORM (To be completed by parents)

To: The Principal

I/We _____ being the parent/guardian of _____ consent to the administration of medicines specified below and any other notified by me/us in writing as required. This consent shall remain valid unless withdrawn and notified by me/us in writing to the school.

Signed: _____ Date: _____

Relationship with Student: _____

Non Prescription or "over the counter" medications

The following medications are held in the sick bay for the relief of minor pain, vomiting, dehydration, coughs, cold or fever. Please sign beside each medication that you authorize us to administer to your child if required.

Paracetamol: _____

Colipan: _____

Ibuprofen: _____

Gestid: _____

Cough syrup: _____

Heat rub: _____

Throat lozenges: _____

ORS:_____

Multivitamins: _____

Glucose:_____

Antibiotics (Amoxil, Flagyl, Septrin):_____

Please list below any other non-prescription medications that your child may need and the name of the condition being treated.

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……

……

PART C: MEDICAL REPORT (To be completed by a doctor after examination)

Name of Doctor: …….

Hospital: ……

Phone: ……. E-mail: …….

Kindly fill in as appropriate, after medical examination.

Weight: ……

Height: ……

Genotype: ……

Blood group: ……

PCV: ……

Urinalysis: ……

HIV status: ……

Tuberculosis: ……

Hepatitis B: ……

Hepatitis C: ……..

Remarks:……

……

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……

Signature/Date

Kindly submit this form with a medical report.

PART D: IMMUNIZATION RECORD (For nursery pupils only)

VACCINE	TICK IF GIVEN	DATE GIVEN (DD/MM/YY)
Hep BO		
OPV O		
BCG		
OPV 1		
Penta 1		
PCV 1		
Penta 2		
PCV 2		
Rota 1		
Rota 2		
Penta 3		
PCV 3		
Vitamin A		
Measles 1		
Yellow fever		
Conjugate A CSM		
Measles 2		
MMR		
OTHERS		

PART E: ATTESTATION (to be filled by the parent)

I hereby attest that all information provided in this form is valid. I agree to forfeit the admission and any financial commitment already made if any information provided in this form is found to be false and misleading.

Name: _____

Date: _____

Signature: _____