LONG BAY SCHOOL

Medical Assessment Form

Part I: To be complete by Parents/Guardians

**** Mandatory for all students in Grade's 1, 4, 7, 10 and 4-year old Preschool students****

Child's Information	
Full legal Name: _____ (Last) _____ (First) _____ (Middle)	
Date of Birth: _____/_____/_____ (DD/MM/YYYY)	
Address: _____ _____	
Sex: Male Female	
Grade: _____	Age: _____

Mother's Information	
Full legal Name: _____ (Last) _____ (First) _____ (Middle)	
Date of Birth: _____/_____/_____ (DD/MM/YYYY)	
Address: _____ _____	
Mother's Contact Info:	Cell:
Home:	Work:

Father's Information	
Full legal Name: _____ (Last) _____ (First) _____ (Middle)	
Date of Birth: _____/_____/_____ (DD/MM/YYYY)	
Address: _____ _____	
Father's Contact Info:	Cell:
Home:	Work:

Guardian's Information	
Full legal Name: _____ (Last) _____ (First) _____ (Middle)	
Date of Birth: _____/_____/_____ (DD/MM/YYYY)	
Address: _____ _____	
Guardian's Contact Info:	Cell:
Home:	Work:

Family Medical History: (Please Circle)	
Asthma	Heart Disease
Diabetes (Sugar)	Other: _____ _____
Hypertension (high blood pressure)	

Questionnaire:		
Has your child ever had to stay in the hospital?	Yes	No
Date of last admission _____/_____/_____ (DD/MM/YYYY)		
What was the medical problem?		
Does your child have any allergies to medications or food?	Yes	No
If yes, what?		
Which clinic or physician does your child attend?		
Does your child attend a Special Clinic?	Yes	No
Why?		
Does your child have any other medical condition?	Yes	No
Is your child currently on medication	Yes	No
If yes, what is/are the name(s) and dosage?		

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Past II: (To be completed by the Clinician) **Date of Examination:**_____/_____/_____
DD MM YYYY

Vital Signs	
Blood Pressure	Pulse
Temperature	Respiration
Weight (kg.)	Height (cm.)
BMI	BMI Classification:

Physical Exam	Normal	Abnormal	Remarks
General Appearance			
Skin			
Eyes			
Ears			
Nose / Throat			
Teeth			
Glands			
Heart			
Lungs			
Abdomen			
Musculoskeletal			
Genitals			
Nervous System			

(If abnormal please provide findings)

Immunization record (to be completed by clinic)					
Immunization	1st	2nd	3rd	1st Booster	2nd Booster
DPT					
Polio					
HIB					
Hepatitis B					
Pneumococcal					
MMR					
Varicella					

Lab Test Results		
Haemoglobin Level (g/dl)		Mantoux reading and Date:
Vision Test:	**Right Eye: 20/**	**Left Eye: 20/**
Corrective Lenses?		
Hearing Test	Rinne's Test	Weber's Test
Sickle Cell Preparation result and date:		

Recommendations
Medications
Restrictions
Medical Council Registration

Physician's Name: _____

Facility Name: _____

Physician's Signature: _____

Date: _____/_____/_____ **DD/MM/YYYY**

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