Child Plus Learning Centre
Day Care and Pre-School
2 FLorida Avenue, Independence City, Gregory Park P.O.
Tele: 988-4888 / 4289962
email: childplus@gmail.com

APPENDIX II

Early Childhood Institution-Child's Medical Report

Part A TO BE COMPLETED AND SIGNED BY PARENT/ GUARDIAN

NAME OF EARLY CHILDHOOD INSTITUTION _____

CHILD'S NAME _____

DATE OF BIRTH _____ AGE _____YRS _____MTHS SEX: M ☐ F ☐

ADDRESS _____

_____ TELEPHONE NO _____

NAME OF PARENT/ GUARDIAN_____

ADDRESS (H)

_____

ADDRESS (W)

_____

TELEPHONE NO (W) _____ (H) _____ (CELL)_____

EMERGENCY CONTACT INFORMATION (other than parent/guardian)

NAME_____ RELATION _____ TEL. NO_____

ADDRESS_____

FAMILY DOCTOR/HEALTH CLINIC_____

ADDRESS_____

TELEPHONE NO_____

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MEDICAL HISTORY

Please respond by putting a tick (√) 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 condition?

Past history	YES	NO	DATE	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	( )	( )		
❖ High Blood Pressure	( )	( )		
❖ Diabetes Mellitus (sugar)	( )	( )		
❖ Leukemia/ Lymphoma	( )	( )		
❖ Typhoid	( )	( )		
❖ Headaches	( )	( )		
❖ Anemia (weak blood)	( )	( )		
❖ Fainting spell/ giddiness	( )	( )		
❖ Excess Tiredness	( )	( )		
❖ Visual disorder	( )	( )		
❖ Hearing disorder	( )	( )		
❖ Hepatitis B	( )	( )		
❖ Meningitis	( )	( )		
❖ Allergies to medication	( )	( )		

List_____

❖ Other condition _____ ( ) ( ) _____

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HAS YOUR CHILD EVER BEEN ADMINTED TO HOSIPTAL OR HAD SURGERY? YES NO

If yes , please explain for what reason

_____

_____

_____

_____

REGULAR MEDICATION TAKEN (IF ANY) _____

FAMILY HISTORY

Has any family member been diagnosed with the following?

	YES	NO	REMARKS
❖ Asthma	( )	( )	_____
❖ Allergies	( )	( )	_____
❖ Diabetes Mellitus	( )	( )	_____
❖ Tuberculosis	( )	( )	_____
❖ Cancer/ Tumors	( )	( )	_____
❖ Sickle Cell Disease	( )	( )	_____
❖ Mental Disorder	( )	( )	_____
❖ Migraine	( )	( )	_____
❖ High Blood Pressure	( )	( )	_____

I certify that the above information is correct

SIGNATURE _____ DATE_____

(PARENT/ GURADIAN)

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PART B MEDICAL EXAMINATION REPORT – To be completed by a physician

Please give details of findings and verify immunization history

CHILD'S

NAME_____02_____

DATEOF BIRTH _____AGE_____HEIGHT_____WEIGHT_____

BP_____ URINALYISIS PROTEIN _____ SUGAR _____

GENERAL APPEARANCE_____ NUTRITIONAL STATE _____

POSTURE _____ TEETH/GUMS_____

SKIN _____ HAIR/SCALP_____

EYES_____ VISION R_____ L _____

(INDICATE WHETHER TESTED WITH GLASSES OR NOT)

EARS _____ NOSE_____ THROAT_____ HEARING_____

BREAST _____ THYROID_____

RESPIRATORY SYSTEM _____

CARDIVASCULAR SYSTEM_____

ABDOMEN/ GI STYSTEM_____

CENTRAL NERVOUS SYSTEM_____

BONESA AND JOINT _____ DEFORMITIES/ DISABILITIES_____

GENITO URINARY SYSTEM_____

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Immunization History: Please indicate date

_____	_____	_____
DOCTOR'S NAME (WRITTEN)	MOJ REG#	DATE