SHORTWOOD TEACHERS' COLLEGE

MEDICAL REPORT FORM

(For students returning to the college)

PERSONAL DATA

STUDENT'S NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

_____

TELEPHONE #: _____

NAME OF PARENT/GUARDIAN/NEXT OF KIN: _____

TELEPHONE #: _____

TO THE PRINCIPAL

This is to certify that on the _____I examined

Miss/Mrs/Mr. _____ Age____ Years

Address: _____

Non-disclosure of health conditions could result in your being asked to withdraw from a program of study.

MEDICAL

Are you on any prescription drugs? _____ If yes, list them

_____

_____

Do you smoke? _____

G.C.S Rh Fever_____ Congenital defects_____ Heart Disease_____

G.I.T. Indigestion_____ Ulcer_____ Appendicitis_____ G.E.R.D._____

C.N.S Anxiety Attacks_____ Nervousness_____ Nervous breakdown_____

Migraine_____ Mental illness_____ Epilepsy_____ Other_____

Asthma_____ Allergies_____ Hypertension: _____ Diabetes: _____

Family History_____

Have you ever been admitted to the hospital? _____ if yes, state reason and date of

admission_____

_____

_____

EXAMINATION

Height: _____ Weight: _____

Eyes: L_____ R_____ Colour Vision_____ Glasses: _____

Urine: Alb_____ Sugar_____ ph _____ S.G._____ Others_____

Heart: _____ B/P_____

Lung: _____

E.N.T: _____Teeth: _____

Abdomen: _____

LMP: _____ Pregnancy: _____ Dysmenorrhoea: _____

Skin_____

Skeletal: _____

Psychological State: _____

Indicate any additional health/ disability related problems that should from part of student's health record_____

_____

_____

Comments/Recommendations:

_____

_____

_____ _____

PRACTITIONER'S NAME (WRITTEN) ADDRESS OF HEALTH FACILITY

Signed: _____ (Medical Officer) Stamp