SHORTWOOD TEACHERS' COLLEGE

MEDICAL REPORT FORM

STRICTLY CONFIDENTIAL

(For students entering college, year 1)

PERSONAL DATA

STUDENTS' NAME: _____

DATE OF BIRTH: _____ AGE: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

NAME OF PARENT/ GUARDIAN /NEXT OF KIN: _____

TELEPHONE NUMBER: _____

TO THE PRINCIPAL

This is to certify that on the _____ I examined.

Miss/Mrs./Mr. _____

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 1. _____2. _____3. _____4. _____ Do you smoke? _____

Past History: Measles: _____ Mumps: _____ Pneumonia: _____ Tonsillitis: _____

Asthma: _____ Food/Medication allergies: _____ Fever: _____
Bronchitis: _____ Chicken Pox: _____ Dengue _____ Sickle Cell Disease: _____

Rh fever: _____ Congenital defects: _____ Heart Disease: _____

Indigestion: _____ Ulcer: _____ Appendicitis: _____ G.E.R.D: _____

Polio: _____ Anxiety Attacks: _____ Nervousness: _____ Nervous breakdown: _____

Migraine Headache _____ Mental illness: _____ Epilepsy: _____ Others: _____

Family History: _____

Skeletal:

Deformity: _____ Fractures: _____ Joint Diseases: _____ Others: _____

Metabolic:

Diabetes: _____ Thyroid: _____ Obesity: _____ Others: _____

Gynecological:

LMP: _____ Dysmenorrhea: _____ Abnormal Bleeding: _____ Menstrual Cycle: _____

Pregnancy/Pregnancies: _____ Trimester of pregnancy: _____

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

EXAMINATION

Height: Ft. _____ Inches _____ Weight: _____ Lbs.

Eyes: Left _____ Right _____ ColourVision: _____ Glasses: _____

Urine: Alb _____ Sugar: _____ Ph: _____ S.G.: _____ Others: _____

Heart: _____ B/P: _____ Lungs: _____

E.N.T: _____ Teeth: _____

Abdomen: _____

Skin: _____

Psychological State: _____

Please indicate date for the following immunization record

Tet Tox: _____ Rubella: _____ Polio: _____ BCG: _____

LAB REPORT

Hb: _____ Gms. VDRL: _____ PCV: _____ Bld.Gp: _____

Stool: Ova parasites: _____ Blood: _____ Urinalysis: _____

Indicate any additional health/disability related problems that should form part of the student's health record: _____

Comments/Recommendations: _____

_____ _____

PRACTITIONER'S NAME (WRITTEN) ADDRESS OF HEALTH FACILITY

Signed: _____ Date: _____

Revised February 12, 2024