SHORTWOOD TEACHERS' COLLEGE

MEDICAL REPORT FORM

STRICTLY CONFIDENTIAL

(For students returning to the college, years 2, 3 and 4)

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 prescription drugs? _____ If yes, List them 1. _____2. _____3. _____4. _____ Do you smoke? _____

Medication/Food Allergies _____

Rh fever: _____ Congenital defects: _____ Heart disease: _____

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

Anxiety Attacks: _____ Nervousness: _____ Nervous breakdown: _____

Migraine Headache: _____ Mental illness: _____Epilepsy: _____ Other: _____

Asthma: _____ Hypertension: _____ Diabetes: _____

Family History: _____

_____

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 _____ Colour Vision: _____ Glasses: _____

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

Heart: _____ B/P: _____

Lung: _____

E.N.T: _____ Teeth: _____

Abdomen: _____

L.M.P: _____ Dysmenorrhea: _____ Pregnancy: _____ Trimester of pregnancy: _____

Skin: _____

Skeletal: _____

Psychological State: _____

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

_____

_____

Comments/Recommendations: _____

_____

_____

_____ _____

PRACTITIONERS NAME (WRITTEN) ADDRESS OF HEALTH FACILITY

Signed: _____ Date: _____

Revised February 12, 2024