CHILD'S MEDICAL REPORT FORM
TO BE COMPLETED AND SIGNED BY PARENT

NAME OF EARLY CHILDHOOD INSTITUTION:_____

PERSONAL DATA

CHILD'S NAME:_____

DATE OF BIRTH: _____/_____/_____/ AGE:_____YRS:_____MONTHS 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.: _____

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 conditions?

PAST HISTORY	YES	NO	DATE(s)	REMARKS
❖ ASTHMA	( )	( )	_____	
❖ BRONCHITIS	( )	( )	_____	
❖ TUBERCULOSIS (TB)	( )	( )	_____	
❖ DISORDERS OF THE EAR/NOSE/THROAT	( )	( )	_____	
❖ RHEUMATIC FEVER/RH. HEART DISEASE	( )	( )	_____	
❖ HEART DISEASE	( )	( )	_____	
❖ EPILEPSY (FITS)	( )	( )	_____	
❖ MENTAL DISORDERS	( )	( )	_____	

	YES	NO	REMARKS
❖ LEARNING DISABILITY	( )	( )	_____
❖ PHYSICAL DISABILITY	( )	( )	_____
❖ DISORDERS OF THE KIDNEY/BLADDER	( )	( )	_____
❖ DISORDER OF STOMACH/BOWELS	( )	( )	_____
❖ SICKLE TRAIT/DISEASE	( )	( )	_____
❖ HIGH BLOOD PRESSURE	( )	( )	_____
❖ DIABETES MELLITUS (SUGAR)	( )	( )	_____
❖ LEUKEMIA/LYMPHOMA	( )	( )	_____
❖ TYPHIOD	( )	( )	_____
❖ HEADACHES	( )	( )	_____
❖ ANAEMIA (WEAK BLOOD)	( )	( )	_____
❖ FAINTING SPELLS/GIDDINESS	( )	( )	_____
❖ EXCESS TIREDNESS	( )	( )	_____
❖ VISUAL DISORDERS	( )	( )	_____
❖ HEARING DISORDERS	( )	( )	_____
❖ HEPATITIS B	( )	( )	_____
❖ MENINGITIS	( )	( )	_____
❖ ALLERGIES TO MEDICATION	( )	( )	_____
❖ OTHER CONDITION	( )	( )	_____

HAS YOUR CHILD EVER BEEN ADMITTED TO HOSPITAL OR HAD SURGERY? YES ☐ NO ☐

If yes please explain for what reason.

_____

_____

REGULAR MEDICATION/S TAKEN (IF ANY):_____

FAMILY HISTORY

Has any family member been diagnosed with the following?

	YES	NO	REMARKS
❖ ASTHMA	( )	( )	_____
❖ ALLERGIES	( )	( )	_____
❖ DIABETES MELLITUS	( )	( )	_____
❖ TUBERCULOSIS	( )	( )	_____
❖ CANCER/TUMOURS	( )	( )	_____
❖ SICKLE CELL DISEASE	( )	( )	_____
❖ MENTAL DISORDER	( )	( )	_____
❖ HEART DISEASE	( )	( )	_____
❖ MIGRAINE	( )	( )	_____
❖ HIGH BLOOD PRESSURE	( )	( )	_____

I _____ certify that the above information is correct.

PARENT'S SIGNATURE: _____ DATE: _____