Aquila Nidus
EDUCATE. DEVELOP. TRANSFORM

MEDICAL RECORDS

Part I – HEALTH INFORMATION FORM

Full Name of the Child (Surname first)

Date of Birth

Birth History (e.g. Weight, Premature and any other problems at birth)

List all prescriptions and over-the-counter medications taken regularly by your child

List names and addresses of medical specialists or special clinics caring for your child

Has your child ever been seen by a Dentist? Yes ☐ No ☐

If yes, date of last appointment

Name & Address of Dentist

Has your child had any operations and hospitalizations? (If yes, please provide details and date)

Mention any other important health related information about your child

Allergies (Food, medicine, in sect bites and any other allergies)

Does your child use any of the following?

Glasses/Contact Lenses ☐ Hearing Aid ☐ Dentures/braces ☐

Tick here if you want to discuss confidential information with the school nurse or the school authority

Yes ☐ No ☐

CHRONIC, RECURRING AND SPECIAL HEALTH CONDITIONS

(Please tick the relevant boxes if your child has any of the following conditions)

	Yes	**No**
Arthritis (Rheumatoid)	☐	☐
Asthma	☐	☐
Attention – Deficit Hyperactivity Disorder	☐	☐
Behavioural or Developmental Problems	☐	☐
Dental Problems	☐	☐
Diabetes	☐	☐
Hearing Impairment	☐	☐
Heart Disease	☐	☐
Kidney Disease	☐	☐
Seizures	☐	☐
Sickle cell Disease (not trait)	☐	☐
Visual Impairment	☐	☐
Hemophilia	☐	☐
Others	☐	☐

IMMUNIZATION RECORDS

Age of child	Vaccine	Date Given	Place Given
Birth	Hepatitis B_1		
	Polio $_0$		
	Tuberculosis		
4-6 Weeks	Hepatitis B_2		
6 Weeks	Poliomyelitis$_1$ DTP_1 Diphtheria Tetanus & Pertussis Hib_1 Haemophilus Influenza type B		
10 Weeks	Poliomyelitis$_2$ DTP_2 Diphtheria Tetanus & Pertussis Hib_2 Haemophilus Influenza type B		
14 Weeks	Poliomyelitis$_3$ DTP_3 Diphtheria Tetanus & Pertussis Hib_3 Haemophilus Influenza type B		
6-9 Months	Hepatitis B Booster		
9 Months	Measles		
1 Year	Yellow Fever		
	Varicella (Chicken Pox)		
15-18 Months	MMR (Measles, Mumps & Rubella)		
18 Months	Poliomyelitis Booster		
	DTP Booster Diphtheria		
	Tetanus & Pertussis Hib Booster Haemophilus Influenza type B		
From 2 Years	Typhoid Fever		
	Meningitis A + C		
	Pneumococcal Infections		
4-6 Years	DTP Diphtheria Tetanus & Polio		
	MMR Measles, Mumps & Rubella		
10-11 Years	DTP Diphtheria Tetanus & Polio		

Signature of Parent or Legal Guardian: ………………………………………………………….. Date: ……………………………………………

Part II – COMPREHENSIVE PHYSICAL EXAMINATION REPORT
(To be completed by a qualified physician)

All components, unless otherwise indicated are to be carried out no earlier than six months prior to the date the child is admitted to the school.

Child's Name (Surname First) ____________________

Date of Birth ____________ Height ________ Weight ________

Blood Pressure ________ Hemoglobin ________

Urine: Albumin ______ Urine: Sugar ______

Results of Mantoux tuberculin skin test, optional (may be required in high-risk groups) ________ mm

Date of test ____________ If performed, date of most recent blood lead level ____________

Results ____________ ug/dl

Systems Examination		Examined	Not Examined	Comments about findings
General Appearance				
Nutritional Status				
Posture/Motor Behaviour				
Skin				
Head				
Eyes	External			
	Fundi			
Ears	External and canal			
	Tympanic Membrane			
Nose				
Throat				
Mouth/Teeth				
Neck				
Heart				
Lungs				
Abdomen				
Bones, Joints, Muscles				
Neurological				
Estimated Developmental Level	Cognitive Development			
	Speech/Language Development			
	Social/Emotional Development			
	Health Behaviors			
	Health habits			

Vision Screening

Distance visual acuity screening results: Without correction: Right eye 20/___ Left eye 20/___ Both eyes 20/___

Distance visual acuity screening results: With correction: Right eye 20/___ Left eye 20/___ Both eyes 20/___

If performed, stereopsis screening result: Pass ☐ Fail ☐

Child to be re-screened? Yes ☐ No ☐ Child to be referred? Yes ☐ No ☐

Hearing

Hearing screening results: Right ear ☐ Left ear ☐ Equipment used ☐

If performed, hearing evaluation results: Right ear ☐ Left ear ☐

If indicated, Tympanogram: Normal ☐ Abnormal ☐

Child to be re-screened? Yes ☐ No ☐ Child to be referred? Yes ☐ No ☐

(Summary of abnormal physical findings)

If any ☐

Physical diagnosis ☐

Describe specifically what, if any, conditions are found that would identify the child as having disability, including conditions that might require

1. Educational evaluation: ____
2. Environmental adjustment: ____
3. Activity limitation: ____

Assessment ☐

Recommendations and referrals made, if any

☐

Physician's address: ____

Physician's name (Print):______________________________ Phone number: ____________________________

Signature of Physician: _______________________________ Date: ____________________________________