PARALEGAL TRAINING INSTITUTE

47C OLD HOPE RD.
KINGSTON 5

MEDICAL FORM FOR STUDENTS

Surname:_____ **First Name:**_____ **Middle Initial**_____

Date of Birth:_____ **Age:**_____ **Sex:** **M** ◯ **F** ◯

Address:_____

_____ **Telephone Number (s) (H)**_____**(C)**_____

EMERGENCY CONTACT PERSON

Name:_____ **Relationship:**_____

Address:_____

_____ **Telephone Number (s) (H)**_____**(C)**_____

Medical History : Please tick ( ) beside the appropriate column if the patient has ever been diagnosed and or treated for any of the following. State the number of years afflicted with the disease and any comments if necessary.

Disease	**No. of years suffered**	**Comments**
Fits/ Epilepsy	_____	_____
Fainting spells	_____	_____
Disorders of sight	_____	_____
Disorders of hearing	_____	_____
Bleeding disorder	_____	_____
Sickle Cell	_____	_____
Sinusitis	_____	_____
Asthma	_____	_____

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Disease	No. of years suffered	Comments
Bronchitis	_____	_____
Chest Pain	_____	_____
Rheumatic Fever	_____	_____
Heart Disease	_____	_____
Diabetes	_____	_____
Stomach Disorder	_____	_____
Disorder of the bowels	_____	_____
Disorder of the liver	_____	_____
Disorder of the kidney	_____	_____
Disorder of the bladder	_____	_____
Dysmenorrhoea	_____	_____
S.T.D	_____	_____
Drug Addiction	_____	_____
Childhood Illnesses :		
Chicken Pox	_____	_____
Diphtheria	_____	_____
Measles	_____	_____
Typhoid Fever	_____	_____
Whooping Cough	_____	_____
Tuberculosis	_____	_____
German Measles	_____	_____
Polio	_____	_____
Any Major Accidents	_____	_____
Any Surgical Operations	_____	_____
Behavioral Problems	_____	_____

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Mental Problems _____ _____

Immunization

Please indicate the date (month and year) that each of the following was received :

	1st.	2nd.	3rd.	1st. Booster
D.P.T				
Polio				
B.C.G				
Measles				
Rubella				
M.M.R				

To be completed by the physician attending to the patient.

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Name of Patient

_____

Age :_____ D.O.B:_____ Sex:_____

Tel. No. (s):_(H)_____(C)_____ Allergies:_____

Date of Examination:

_____

LMP_____ Menarche_____

Height_____ Weight_____

Temperature_____ Pulse_____

B/P_____ Urinalysis_____

Vision: RE_____ LE_____

Hearing: RE_____ LE_____

LABORATORY TESTS (optional): Hemoglobin level :_____

Pregnancy Test:_____

Present Findings: N=NORMAL A=ABNORMAL (state clearly the abnormality)

_____ General appearance_____

_____ Posture_____

_____ Eyes_____

_____ Ears_____

_____ Nose_____

_____ Throat_____

_____ Teeth & Gum _____

_____ Muscosa_____

_____ Skin_____

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_____ Scalp_____

_____ Thyroid_____

_____ Lymph glands_____

_____ Heart_____

_____ Lungs_____

_____ Musculo-skeletal system_____

_____ Nervous system_____

_____ Abdomen_____

_____ Puberty signs_____

Please indicate any current medication and/or medication prescribed.

Physician's comments and recommendation (particularly student's ability to participate in all kinds of SPORTS).

_____
_____
_____
_____

I _____ of _____

(Doctor's Name) (Medical Facility)

Signature:_____ Date:_____

OFFICIAL STAMP