Temple Christian Elementary School

Fourth Terrace, Centreville
Nassau, Bahamas
P.O. Box N-1566
325-1119/ 325-3245

MEDICAL FORM

PART A (To be completed by parent/ guardian. Please print.)

Student's name: _____ **Gender**: _____
Last First Middle

Place of birth: _____ **Date of birth:** _____
City Country dd/mm/yy

Address: _____ **Home phone:** _____
P.O. Box House No. and Street

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PART B (To be completed by examining physician)

Height: _____ft. _____in. (_____m. _____cm.) **Weight:** _____lbs. (_____kg.)

Family history of illnesses (Please tick)
Asthma _____ Allergies _____
Cancer _____ Diabetes _____
Epilepsy _____ Fainting spells _____
Nose bleeds _____ Rheumatic fever _____
Any other disease _____

Immunization (Must be up to date)

DPT	**POLIO**
1 _____	1 _____
2 _____	2 _____
3 _____	3 _____

Booster (1) _____ (2) _____ DT _____
MMR (1) _____ (2) _____ (3) _____
Other: _____
_____
_____

Student history of illnesses (Please tick)
Asthma _____ Allergies _____
Cancer _____ Diabetes _____
Hypertension _____ Sinusitis _____
Nose bleeds _____ Rheumatic fever ___
Stomach problems ___ Sickle cell disease____
Chest pains/ pressure _____ Pneumonia ____
Fever seizures _____ Epilepsy ____ Other_____
State any present disease or condition
_____
_____

State if patient has had the following:
Measles _____
Chicken Pox _____
Whooping Cough _____
Tuberculosis _____
Mumps _____
Polio _____
State any exposure within the past six months to any other contagious disease.
_____

Teeth
Date of last exam _____
Reason _____
Condition _____
_____
_____
_____
_____

General emotional health
(Answer **Yes** or **No**)
Frequent trouble sleeping _____
Behavioral problems_____
Temper tantrums _____
Depression or excessive worry _____
Anorexia _____
Nailing biting _____
Any other _____

Hearing
Date of last exam_____
Condition_____
_____
_____

Presently under doctor's care _____
Present medication(s) and dosage _____
_____
_____

Eyes
Date of last exam_____
Condition_____
_____
_____

Required Laboratory Tests

CBC (complete blood count) _____
Urinalysis _____
Stool test _____

Comments

_____
_____
_____

Physical activity

Note to doctor: With the present emphasis on physical fitness, the medical examination becomes even more important as administration needs to know each student's capabilities and limitations. The information below will be used to determine the child's Physical Education program.

Please check each item yes or no in the table below. Each item checked "Yes" should be explained in the right hand column of the table and should be accompanied by a letter from the doctor if the child needs to be excused from Physical Education classes and Sports. If a doctor's letter is issued, please state "See doctor's letter" in the right hand column of the table.

Question	Yes	No	Comment
Has child had an operation or been advised to take one?			
Does child have an existing sporting injury?			

Can child compete fully in sports, including competitive sports?			
Can child participate in Physical Education, but not competitive sports?			
No participation in sports.			
Limitation only in certain sports.			

Signature of Doctor: _____ Date: _____

Doctor's Name (Please print): _____

Doctor's Stamp/ Seal