Blake Academy

(242) 356-3588
Email: info@blakeacademy.org
Elementary School Website: www.saundersbeachblakeacademy.org
High School Website: www.blakeacademy.org

STUDENT MEDICAL RECORD 2019 - 2020

1. Student Information

Student's Name _____ Grade: _____
First name Middle name Family name

[ ] Male [ ] Female Date of Birth: _____ Home Telephone_____
Month / Day / Year

Home Address: _____
House number Street P.O. Box

Student's Doctor _____
Name Address Telephone

Student's Dentist _____
Name Address Telephone

2. Student Medical History

PARENTS ARE TO COMPLETE **BOTH** SIDES OF THIS FORM AND SIGN IN THE SPACE PROVIDED.
PLEASE ASK YOUR CHILD'S DOCTOR TO COMPLETE THE ATTACHED MEDICAL CERTIFICATE.
Thank you.

	Please X if answer is YES	Date		Please X if answer is YES	Date
Rheumatic Fever			Discharging ears		
Growing Pains			Loss of weight		
Scarlet Fever			Worms		
Diphtheria			Pneumonia		
Whooping Cough			Bronchitis		
Measles			Pleurisy		
German Measles			Tuberculosis		
Chicken Pox			Asthma		
Mumps			Hay Fever		
Fainting Attacks			Any Allergic Condition		
Blackouts			Any Skin Condition		
Kidney Trouble			Epileptic Fits		
Urinary Trouble			Any other type of Fits		
Poliomyelitis			Diabetes		
Handicap – Arms/Hands			Defective Eyesight		
Handicap – Legs/Feet			Sickle Cell Anaemia		
Defective Hearing or Balance			Haemophila or Bleeding Diseases		
Does the child wear hearing aid?			Any known Heart Disease		
Does the child wear glasses?			Cerebral Palsy or Spasticity		

Has the child had any other illness(es) not listed?		Please give the names of the illness(es)	
Is the child on long term medication?		If YES, please write the amount and frequency of the medication	

Has your child had normal growth and development? [ ] Yes [ ] No

Has your child (if female) commenced menstruation? [ ] Yes [ ] No _____
Approximate Date

Has your child had any operations? [ ] Yes [ ] No (If yes, please list operations and dates below)

_____ _____
Summary of Operation Date

_____ _____
Summary of Operation Date

_____ _____
Summary of Operation Date

3. Student's Immunization History

IMMUNIZATION

(Please mark X if the answer is YES. Leave blank if the answer is NO)

	X if YES	Approximate Date		X if YES	Approximate Date
D.P.T. Shots 1st			Oral Polio 1st		
2nd			2nd		
3rd			3rd		
Booster			Booster		
MMR –1			HEP –B		
MMR –2					
HIB			OTHER		

4. Student's Family Medical History

If there is a family history of any of the following, please indicate with an X.

Condition	X if YES	Condition	X if YES
Diabetes		Asthma	
Kidney Disease		Fits (Epileptic/otherwise)	
High Blood Pressure		Sickle Cell Anaemia	
Tuberculosis		Haemophilia/Bleeding Condition	

5. Parent/Guardian Authorization

I HEREBY AUTHORIZE CONSENT IN THE EVENT OF A MEDICAL EMERGENCY OR TREATMENT THAT MAY BE DEEMED NECESSARY DURING THE COURSE OF A SCHOOL DAY.

_____ _____
Parent's/Guardian's Signature Date

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MEDICAL FORM 2019 - 2020

Name of the child: _____

Date of Birth :_____

1. **Are you satisfied that the child has:**

   - ➢ Reasonable eyesight?
     [ ] Yes [ ] No If NO, please comment _____
   - ➢ Normal Hearing?
     [ ] Yes [ ] No If NO, please comment _____
   - ➢ Normal To nsils?
     [ ] Yes [ ] No If NO, please comment _____
   - ➢ Teeth in reasonable condition?
     [ ] Yes [ ] No If NO, please comment _____
   - ➢ Normal Heart and Chest sounds?
     [ ] Yes [ ] No If NO, please comment _____

2. **Is there a history of fits, worms or anaemia?**
   [ ] Yes [ ] No If YES, please comment _____

3. **Does the child have any allergic condition?**
   [ ] Yes [ ] No If YES, please comment _____

4. **Is there a relevant family history of illness?**
   [ ] Yes [ ] No If YES, please comment _____

5. **Is there any reason why this child should not take part in Physical Education classes, sports or swimming lessons?**
   [ ] Yes [ ] No If YES, please comment _____

6. **Are the immunizations up to date? (D.P.T., Polio, etc)**
   [ ] Yes [ ] No If YES, please comment _____

7. **Following your examination, do you feel this child is in a reasonable state of health?**
   [ ] Yes [ ] No If NO, please comment _____

_____	_____	_____
Name of Doctor	Signature of Doctor	Date

Students Medical Form to be completed by a Doctor