# ACCRA GIRLS' SENIOR HIGH SCHOOL
# STUDENT GENERAL MEDICAL EXAMINATION FORM

The information on this form is gathered to assist us in identifying appropriate care for the students during her stay in the school.

## To be filled by Parents/Guardian

Please provide complete information so that health personnel can be aware of your daughter's needs.

Name of student:…… Year of Admission:…….

Date of birth:…….. House:……

Address:…….. Class:……..

## Parent/Guardian Information

Name:……. Contact:……...

Relationship:…….. Address:……..

## Emergency Contact Information

Emergency Contact:……Relationship: ……...

## HEALTH HISTORY (Provide Yes/No where applicable)

Asthma: ☐ :……

Diabetes: ☐ :……

Sickling: ☐ :……...

Peptic Ulcer disease: ☐ :……..

Recent Injury: ☐ :……

Any infectious Disease: ☐ :……

Ear Problem/Infections ☐ :……

Convulsion/Epilepsy/Seizures ☐ :……

Skin Problems (itching/rash/acnes etc) ☐ :……

Frequent Constipation: ☐ :……..

Eye/Sight Impairment ☐ :……

Headaches/Migraines ☐ :……

Eating Disorder ☐ :……..

Nose bleeding ☐ :……..

Emotional difficulties requiring professional help ☐ : ……..

Had surgery or hospitalized in the last 5 years. ☐

Physical disability (if yes specify):……

Others:……..

**NOTE:** For Chronic conditions such as diabetes, asthma, sickle cell disease, convulsion, epilepsy, seizures etc. attach a sheet explaining treatment in details, include frequency of attacks and triggers.

## PHYSICAL EXAMINATION (To be completed by medical officer)

Blood Pressure: ……..

Pulse Rate: ……...

Heart Sound: ……..

Chest x'ray report:……..

Vision: ……

Hearing:……

Lungs: ……

Abdomen:……

Musculo-skeletal system:……

Stool:……

Urine:……..

Haemoglobin level:…….

Sickling Status:……

G6PD:……..

Does the student need regular medical check-up? Yes:……. No:…….

If Yes, how often

Is student on any medication? Yes:…… No:……

If yes, specify medication and duration……
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……
……

MEDICAL OFFICERS COMMENTS
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……..…
……...……...
……

……. …….....

NAME OF MEDICAL OFFICER NAME OF FACILITY

……..… ……..

SIGNATURE & STAMP DATE OF EXAMINATION