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 student 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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……..…
……..……...
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……. …….....
NAME OF MEDICAL OFFICER NAME OF FACILITY

……..… ……..
SIGNATURE & STAMP DATE OF EXAMINATION