

ANSAARU SUNNA ACADEMY – BOYS BOARDING

STUDENT MEDICAL EXAMINATION FORM (TO BE COMPLETED BY A LICENSED MEDICAL DOCTOR)

SECTION A: STUDENT DETAILS (To be filled by Parent/Guardian)

Student Full Name: _____

Admission Number (Office Use): _____

Date of Birth: ____ / ____ / ____ Age: ____ Years

Class/Grade Applying For: _____

Gender: Male

Nationality: _____

Parent/Guardian Name: _____

Relationship to Student: _____

Phone Number: _____

Alternative Phone: _____

Home Address: _____

Emergency Contact Person: _____

Emergency Phone Number: _____

SECTION B: MEDICAL HISTORY (Parent/Guardian to fill before visiting doctor)

1. Has the student ever been admitted to hospital? YES [] NO []

If YES, explain: _____

2. Does the student suffer from any chronic illness?

Asthma [] Epilepsy [] Diabetes [] Heart Disease [] Sickle Cell []

TB [] Allergies [] Other: _____

3. Is the student currently on medication? YES [] NO []

If YES, specify: _____

4. Any food allergies? _____

5. Any drug allergies? _____

6. Any physical disability? _____

7. Any hearing problems? _____

8. Any vision problems? _____

9. Any behavioral or psychological condition? _____

Immunization Status (Attach copy if available)

BCG [] Polio [] DPT [] Measles [] Tetanus [] Hepatitis B []

Other Vaccines: _____

Parent/Guardian Declaration:

I confirm the above information is true and correct.

Name: _____ Signature: _____

Date: ____ / ____ / ____

SECTION C: MEDICAL EXAMINATION (To be completed by a Doctor)

Height: _____ cm Weight: _____ kg

BMI: _____

Blood Pressure: _____

Pulse Rate: _____

Temperature: _____

Blood Group: _____

GENERAL PHYSICAL EXAMINATION

Appearance: Good ☐ Fair ☐ Poor ☐

Nutrition Status: Good ☐ Fair ☐ Poor ☐

SYSTEMIC EXAMINATION

Eyes: Normal ☐ Abnormal ☐ Specify: _____

Ears: Normal ☐ Abnormal ☐ Specify: _____

Nose/Throat: Normal ☐ Abnormal ☐ Specify: _____

Chest/Lungs: Normal ☐ Abnormal ☐ Specify: _____

Heart: Normal ☐ Abnormal ☐ Specify: _____

Abdomen: Normal ☐ Abnormal ☐ Specify: _____

Skin: Normal ☐ Abnormal ☐ Specify: _____

Spine/Posture: Normal ☐ Abnormal ☐ Specify: _____

Neurological: Normal ☐ Abnormal ☐ Specify: _____

Vision Test:

Right Eye: _____ Left Eye: _____

Colour Blindness: YES ☐ NO ☐

Hearing Test: Normal ☐ Impaired ☐

SECTION D: LABORATORY TESTS (Recommended)

Hemoglobin: _____

Urinalysis: _____

Stool Test: _____

Other Tests: _____

SECTION E: DOCTOR'S ASSESSMENT

Is the student physically fit for school activities? YES ☐ NO ☐

Is the student fit for sports activities? YES ☐ NO ☐

Any restrictions or special care required:

Additional remarks:

SECTION F: DOCTOR'S CERTIFICATION

I hereby certify that I have examined the above student and the information given is true to the best of my professional knowledge.

Doctor's Name: _____

Medical Registration Number: _____

Hospital/Clinic: _____

Address: _____

Phone Number: _____

Signature & Official Stamp: _____

Date: ____ / ____ / ____

FOR SCHOOL USE ONLY

Reviewed by School Administration: _____

Comments: _____

Accepted ☐ Not Accepted ☐

Signature: _____ Date: ____ / ____ / ____