One Voice, One Bus, One Direction!

ANGLICAN CENTRAL EDUCATION AUTHORITY

EXCELLENCE EQUITY OPPORTUNITY

The Anglican Central Education Authority

Diocese of The Bahamas and
Turks and Caicos Islands
Addington House
Sands Road
P. O. Box N-656
Nassau, N.P
The Bahamas
Tel.: (242) 322-3015-9
Fax: (242) 325-2647

PART I: To be completed by Parents/Guardians

Child's Name: _____
Last First Middle

Date of birth: _____/_____/_____ Age: _____ Sex: M( ) F( )
D M Y

Address: _____

Name of School: _____

Mother's name: _____

Mother's date of birth: _____/_____/_____ Address: _____

Phone: Home: _____ Work: _____ Cell: _____

Father's name: _____

Father's date of birth: _____/_____/_____ Address: _____

Phone: Home: _____ Work: _____ Cell: _____

Guardian (if applicable) _____ Phone: _____

Family Medical History:
(a) Diabetes (sugar)
(b) Hypertension (high blood pressure)
(c) Heart Disease
(d) Other _____
(e) Asthma
(f) Epilepsy
(g) Sickle Cell

Has your child ever had to stay in hospital? Yes ( ) No ( )

When? _____ What was the Medical problem? _____

Does your child have any allergies to medications, food, insect stings, etc. ? Yes ( )No ( )

If yes what? _____

Which Clinic or Physician does your child attend? _____

What is the Clinic Medical record number? _____

Does your child attend a Special Clinic? _____

Why? _____

Are there any medical conditions with your child that you would like to bring to the Doctor's attention?

_____

_____

Is your child currently on medication? Yes ( ) No ( )

If yes what is/are the name(s) and dosage _____

_____

Date of Examination: _____

PART II: To be completed by the Physician

Vital Signs
Blood Pressure
Temperature
Pulse
Respiration
Weight
Height
BMI

Physical Examination	Normal	Abnormal Remarks
General appearance		
Skin		
Eyes		
Ears		
Nose/Throat		
Teeth		
Glands		
Heart		
Lungs		
Abdomen		
Musculoskeletal		
Genitals		
Nervous System		

(If abnormal please provide findings)

Immunization record (to be completed by clinic)

- **Please submit a copy of the immunization card to school**

Immunization	1st	2nd	3rd	1st Booster	2nd Booster
DPT					
Polio					
HIB					
Hepatitis B					
Pneumococcal					
MMR					
Varicella					
Other vaccines					

PART III: Laboratory Test Results:

CBC: _____ HB: _____ Urinalysis: _____

Mantoux date and results: _____

Vision Test: _____

Hearing Test: _____

PART IV: Recommendations:

_____

_____

Medications: _____

Restrictions: _____

Physician's Name: _____ Signature: _____ Date: _____

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MEDICAL CONSENT FORM

I _____ give consent for my child/ward
(Parent's/Guardian's Name)

_____ to be treated at Doctor's
(Child/Ward's Name)

Hospital should an emergency arise during school hours, or during a school function.

_____ _____
(Parent/Guardian's Signature) Date

Please
Contact: _____ Phone: _____

Emergency
Contact: _____ Phone: _____

(Please note that in case of any serious ILLNESS or INJURY students will be transported to hospital via ambulance).

PREFERRED MEDICAL SERVICE

I do not wish my child/ward to be treated at Doctor's Hospital. Please refer

_____ to _____
(Child/Ward's Name) (Medical facility or /Doctor's name)

Please
Contact: Phone:

Emergency
Contact: _____ Phone: _____

(Please note that for preferred Medical Facility parents agree to pay cost of ambulance service).

_____ _____
Parent / Guardian Signature **Date**

Providing quality education in a Christian environment by developing the whole child spiritually, academically, physically and socially and is so doing prepare the child for life.