GOVERNMENT of JAMAICA
MINISTRY OF LABOUR & SOCIAL SECURITY

Jamaica Council for Persons with Disabilities
EDUCATING • ADVOCATING • EMPOWERING

Jamaica Council for Persons with Disabilities

Medical Report for Children

JCPD CHILDREN MEDICAL FORM
Hearing/Visual Assessment

*Kindly complete this form for **all** clients based on the disability identified. For guidelines on the criteria for identifying the disability please see attached guidelines. **Form is to be completed in BLOCK letters***

Name ____ Male ☐ Female ☐
Last Name First Name Middle Name(s)

Age: ____________ **Date of Birth**: ________/________/________ **Nationality**: ________________
Yr. Mth Day

Home Address: ____

Email Address: ____

Contact Number(s): ______________________/______________________
Home Mobile

Name of Parent/Guardian: ______________________ **Occupation** ______________________

Type of Disability: ____

Nature of Disability:
Temporary ☐ Permanent ☐ Progressive ☐ Improving ☐ Static ☐

Other (*specify*) ____

Date of Disablement: ________/________/________
Yr. Mth Day

Treatment, assistive devices / prosthetic appliances required (*specify*):

____

____

Hearing/Visual Assessment –to be completed by Ophthalmologist or Audiologist

Remarks and General Appraisal

Hearing: Left ☐ Right ☐ Both ☐ **Vision:** Left ☐ Right ☐ Both ☐

Vision: *(Correct if glasses worn)***. The following is suggested:**

☐ **Good:** not less than 6/9 (Snellen), ☐ **Moderate:** less than 6/9 and more than 6/24, ☐ **Bad:** Less than 6/24

Degree of hearing loss: db=decibels

☐	**Mild**	Sounds softer than 25 dB to 40 dB are not detected
☐	**Moderate**	Sound softer than 40 dB to 65 dB are not detected
☐	**Severe**	Sound softer than 65 dB to 90 dB are not detected
☐	**Profound**	Sounds softer than 90 dB are not detected

Treatment/ intervention: Is child in any intervention programme? : Yes ☐ No ☐

Specify: ____

____

Cause of Disability/ Etiology: ____

____

____

Any other comments: ____

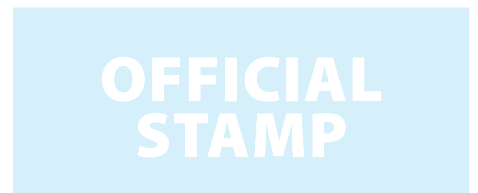
____

____

____ ______/______/______

SIGNATURE OF PARENT/CAREGIVER **Date:** Yr. Mth Day

Name of GP/Orthopedic Specialist: ______________________________



Signature of GP/Orthopedic Specialist: ______________________________

Address/Place of Practice: ____

Contact Number: ______________________________ **Email**: ______________________________

Date of Completion: ______/______/______

Yr. Mth Day