GOVERNMENT *of* JAMAICA
MINISTRY OF LABOUR & SOCIAL SECURITY

Photo

## Jamaica Council for Persons with Disabilities

# *Medical Report for Children*

**The purpose of this report is to identify medical problems that would mitigate against schooling or other integrated childhood activities.**

MEDICAL REPORT SUMMARY FOR CHILDREN FORM SECTION: **A**

**Name**: _____ _____ _____ Male ☐ Female ☐
Last Name First Name Middle Name

Age: _____ Date of Birth: _____/_____/_____ Nationality: _____
Day Mth Yr.

**Address**: _____

_____

**Telephone**: (*Home*) _____ **Cel:** _____ **Parish:** _____

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

**Address if different from above**: _____

_____

**Telephone**: (*Home*) _____ **Cel:** _____

**Type of Disability** (what function is affected): _____

_____

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

Other (specify): _____

**Degree of disablement:** Minimal ☐ Mild ☐ Moderate ☐ Severe ☐ Profound ☐

**Other disablement** (if any): _____

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

_____

_____

**Medical diagnosis** (cause): _____

_____

**Name of person completing form** : _____

**Address**: _____

_____

**Telephone**: _____ **Cel:** _____

**Jamaica Council for Persons with Disabilities**

# *Medical Report for Children*

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MEDICAL REPORT SUMMARY FOR CHILDREN FORM SECTION: **A**

## Functional Assessment **(Revised medical form for children page 2)**

- ☐ **Use of Hands** Seizing, holding, grasping, or otherwise working with the whole hand or arm;
- ☐ **Use of Fingers** Pickup, pinching, gripping between thumb and fingers, or otherwise working with the fingers,
- ☐ **Balancing** Maintain position whether sitting, standing or bending forward without holding on or being held .
- ☐ **Walking**
- ☐ **Travel to school** By public transport

**Hearing:** Left ☐ Right ☐ Both ☐

**Vision:** (Corrected if glasses worn).The following suggested):
☐ **Good:** not less than 6/9 (Snellen), ☐ **Moderate:** less than 6/9 and more than 6/24, ☐ **Bad:** less than 6/24

## Intelligence/ Cognitive Functioning

**Level of Functioning:**
Mild; Intermittent ☐ Moderate; Limited ☐ Severe; Extensive ☐ Profound; and Pervasive ☐

**Date of Initial diagnosis**: _____/_____/_____ **Age at Diagnosis**: _____
Day Mth Yr.

**Name of Clinician/Doctor**: _____

**Address**: _____

**Telephone**: _____ **Date of last psychological evaluation**: _____/_____/_____
Day Mth Yr.

**Name of Clinician/Doctor**: _____

**Address**: _____

_____

**Telephone**: _____ **Email**: _____
*(Please attach a proof of evaluation to this form)*

## Remarks and General Appraisal

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

**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** Sounds softer than 65 dB to 90 dB are not detected
- ☐ **Profound** Sounds softer than 90dB are not detected

**Treatment/ intervention: Is child in any intervention programme?** YES ☐ NO ☐

Specify: _____

**Cause of Disability/Etiology** : _____

**Any other comments**: _____

_____ _____/_____/_____
SIGNATURE OF APPLICANT DATE

**Name of professional completing the assessment**: _____

**Address**: _____