GOVERNMENT *of* JAMAICA
MINISTRY OF LABOUR & SOCIAL SECURITY

Jamaica Council for Persons with Disabilities
EDUCATING • ADVOCATING • EMPOWERING

Photo

Jamaica Council for Persons with Disabilities

Medical Report for Children

JCPD CHILDREN MEDICAL FORM
Functional 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*):

_____

_____

*Complete this section if child has **Physical Disability**. For guidelines on the completion of Form see attached criteria. The purpose of this report is to identify medical challenges that would mitigate against schooling or other integrated childhood activities.*

Functional Assessment – to be completed by General Practitioner /Orthopedic Specialist

Indicate ability in words and percentages, e.g. 'moderate' - M, weak'- W; 'poor' – P; 'nil' - N

- ☐ **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

Cause of disability/Medical Diagnosis: _____

_____

_____

Additional Comments: _____

_____

_____

_____

_____ _____/_____/_____

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

Name of GP/Orthopedic Specialist: _____

Signature of GP/Orthopedic Specialist: _____

OFFICIAL STAMP

Address/Place of Practice: _____

Contact Number: _____ **Email**: _____

Date of Completion: _____/_____/_____

Yr. Mth Day