



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

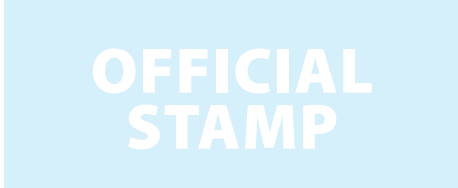
Cause of disability/Medical Diagnosis: _____

Additional Comments: _____

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

Name of GP/Orthopedic Specialist: _____

Signature of GP/Orthopedic Specialist: _____



Address/Place of Practice: _____

Contact Number: _____ **Email:** _____

Date of Completion: _____/_____/_____
Yr. Mth Day