





Jamaica Council for Persons with Disabilities Medical Report for Children

JCPD CHILDREN MEDICAL FORM Intelligence/Cognitive 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	e First Name		Middle Name(s)		_	_	
Age:	Date of Birth:	///	Mth Day	Nationality:			
Home Address:							
Email Address:							
Contact Number(s):	Home			Mobile			
Name of Parent/Guardia	an: Occupation						
Type of Disability:							
Nature of Disability: Temporary	Permanent 🗌	Progr	essive 🗌	Improving		Static 🗌	
Other (specify)							
Date of Disablement: _	Yr.	Mth	Day				
Treatment, assistive dev	vices / prosthetic app	liances requ	uired (specify):				

Intelligence/Cognitive Assessment –to be completed by Registered Psychologist (e.g. Psycho-Educational or Clinical) To be completed if child has Intellectual or Developmental Disability

Intelligence/Cognitive F	unctioning (Level	of Intellectual Fun	action & Type of Support	Needed)	
Mild: Intermittent	Moderate	Limited 🗌	Profound; and Pervasiv	Profound; and Pervasive	
Cause of Disability/Medic					
Age at Diagnosis:	Date of Initial diagnosis:///				
Name of Clinician:					
Address:					
Telephone Contact:	D	ate of last psycholo	ogical evaluation:Yr.	Mth Day	
SIGN	IATURE OF PARENT/0	CAREGIVER	Date: Yr.	Mth Day	
Name of Clinician:					
Signature of Clinician:					
Address/Place of Practice:					
Contact Number:		Email	:		
Date of Completion:	Yr. Mth	/			