



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
**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 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):

