



GOVERNMENT  
of JAMAICA  
MINISTRY OF LABOUR  
& SOCIAL SECURITY



Jamaica Council for  
Persons with Disabilities  
EDUCATING • ADVOCATING • EMPOWERING



**Jamaica Council for Persons with Disabilities**

*Medical Report for Children*

JCPD CHILDREN MEDICAL FORM  
**Hearing/Visual 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):  
 \_\_\_\_\_  
 \_\_\_\_\_

# Remarks and General Appraisal

Hearing: Left  Right  Both  Vision: Left  Right  Both

Vision: (Correct if glasses worn). The following is suggested:

**Good:** not less than 6/9 (Snellen),  **Moderate:** less than 6/9 and more than 6/24,  **Bad:** Less than 6/24

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

Treatment/ intervention: Is child in any intervention programme? : Yes  No

Specify: \_\_\_\_\_

\_\_\_\_\_

Cause of Disability/ Etiology: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any other comments: \_\_\_\_\_

\_\_\_\_\_

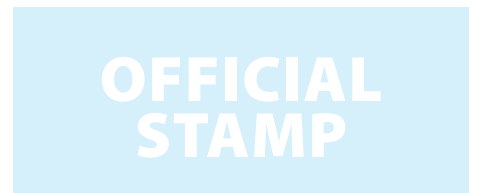
\_\_\_\_\_

\_\_\_\_\_  
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