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
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*):

_____

_____

Hearing/Visual Assessment –to be completed by Ophthalmologist or Audiologist

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: _____

OFFICIAL STAMP

Address/Place of Practice: _____

Contact Number: _____ **Email**: _____

Date of Completion: _____/_____/_____

Yr. Mth Day