



GOVERNMENT of JAMAICA
MINISTRY OF LABOUR & SOCIAL SECURITY



Jamaica Council for Persons with Disabilities

Medical Report for Children

The purpose of this report is to identify medical problems that would mitigate against schooling or other integrated childhood activities.

MEDICAL REPORT SUMMARY FOR CHILDREN FORM SECTION:

A

Name: _____ Male
Last Name First Name Middle Name Female

Age: _____ Date of Birth: ____/____/____ Nationality: _____
Day Mth Yr.

Address: _____

Telephone: (Home) _____ Cel: _____ Parish: _____

Name of Parent/Guardian: _____ Occupation: _____

Address if different from above: _____

Telephone: (Home) _____ Cel: _____

Type of Disability (what function is affected): _____

Nature of Disability: Temporary Permanent Progressive Improving Static

Other (specify): _____

Degree of disablement: Minimal Mild Moderate Severe Profound

Other disablement (if any): _____

Treatment, assistive devices / prosthetic appliances or aids (specify): _____

Medical diagnosis (cause): _____

Name of person completing form : _____

Address: _____

Telephone: _____ Cel: _____





Jamaica Council for Persons with Disabilities Medical Report for Children

The purpose of this report is to identify medical problems that would mitigate against schooling or other integrated childhood activities.

MEDICAL REPORT
SUMMARY FOR CHILDREN
FORM SECTION:

A

Functional Assessment (Revised medical form for children page 2)

- 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

Hearing: Left Right Both

Vision: (Corrected if glasses worn). The following suggested):

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

Intelligence/ Cognitive Functioning

Level of Functioning:

Mild; Intermittent Moderate; Limited Severe; Extensive Profound; and Pervasive

Date of Initial diagnosis: ____/____/____ Age at Diagnosis: _____
Day Mth Yr.

Name of Clinician/Doctor: _____

Address: _____

Telephone: _____ Date of last psychological evaluation: ____/____/____
Day Mth Yr.

Name of Clinician/Doctor: _____

Address: _____

Telephone: _____ Email: _____

(Please attach a proof of evaluation to this form)

Remarks and General Appraisal

Hearing: Left Right Both Vision: Left Right Both

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

Treatment/ intervention: Is child in any intervention programme? YES NO

Specify: _____

Cause of Disability/Etiology : _____

Any other comments: _____

_____/_____/_____
SIGNATURE OF APPLICANT DATE

Name of professional completing the assessment: _____

Address: _____

