



MEDICAL REPORT

Instructions: To be completed by a qualified Medical Practitioner

Child's Particulars:

Name: _____

Birth Cert./ NRIC No.: _____

Sex: _____

Date of Birth: _____

Date of Medical Examination: _____

Birth and Developmental History:

Family History:

Any family member with mental or physical disabilities?

*(If Yes, please specify)

Yes*

No

Medical Background:

Diagnosis: _____

Is child on medication?

Yes*

No

Allergy, if any?

Yes*

No

Diagnosis of psychiatric disorder, if any?

Yes*

No

Physical Examination Result

Height: _____ Weight: _____

Dysmorphic Features: _____

Visual Examination:

Has formal vision test been done?

(If Yes, when?)

Yes*

No

Is child's vision within normal limits?

(If No, please specify)

Yes*

No

R6/ _____

L6/ _____

Squint

Yes*

No

Astigmatism

Yes*

No

Other complications:

Hearing Examination:

Has formal hearing test been done?

(If Yes, when?)

Yes*

No

Is child's hearing within normal limits?

(If No, please specify?)

Yes*

No

Right ear drum: _____

Left ear drum: _____

Other complications:

Other Examination:

Heart: _____

Lungs: _____

Abdomen: _____

Musculoskeletal System: _____

Diagnosis: _____

Remarks/ Recommendation:

Examined by:

Name of Doctor: _____

Signature: _____

Name of Organisation: _____

Date: _____