MADRASSA AN-NOOR FOR THE BLIND
A Specialist Islamic Institute for the Visually Impaired
NPO No: 067-749 • PBO No: 930022978
EST. 1986 / 1406 تاسست
مدرسة النور للمكفوفين

GENERAL HEALTH QUESTIONNAIRE

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Name of Pupil:_____

Gender: _____

Date of Birth: _____

1. State nature of pupils principal handicap (e.g. Blind, Partially-sighted, Deaf, Hard-of-Hearing, etc)

_____

2. Is the pupil suffering from or had any of the following diseases or ailments? Please state Yes/No. If yes, give details of age at onset of illness, duration of illness, treatment, etc, on a separate sheet of paper and attach to this form.

Adenoid defect	☐	Haemorrhages	☐
Aids	☐	Allergy	☐
Heart Disease	☐	Anaemia	☐
Kidney Disease	☐	Appendicitis	☐
Liver Disease	☐	Asthma	☐
Malaria	☐	Amoebic Dysentery	☐
Malnutrition	☐	Backaches	☐
Meningitis	☐	Bilharzia	☐
Measles	☐	Brain Damage	☐
Mumps	☐	Bronchitis	☐
Nervous System/Chorea	☐	Chicken Pox	☐
Nose, Diseases of	☐	Cholera	☐
Pains in limbs	☐	Chest Pains	☐
Pneumonia	☐	Diphtheria	☐
Poisons - intake of	☐	Diabetes	☐
Polio	☐	Ear ache	☐
Rheumatism	☐	Eyes (Burning, painful, bloodshot)	☐
Rapture, a watering	☐	Scarlet fever	☐
Stomach Pains	☐	Epileptic	☐
Teeth	☐	German Measles	☐
Tetanus	☐	Gums Unhealthy/Bleeding	☐
Throat - Diseases of	☐	Glands	☐
Tonsils	☐	Gastro-Enteritis	☐
Tuberculosis	☐	Goitre Typhoid	☐
Hay Fever	☐	Wheezing Chest	☐
Headaches	☐	Whooping Cough	☐

3. What other illness has the pupil had? _____

4. Operations _____

5. Is the pupil complaining of anything at present? _____

6. Does the pupil appear mentally normal? _____

7. Does the pupil present any behaviour problems? _____

8. Was the pupil involved in an accident? _____If yes, please give details of injuries sustained,etc.

Head injury	☐	Body Injuries	☐
Internal Injury	☐	Right hand	☐
Left leg	☐	Left hand	☐
Right leg	☐	Other	☐

9. Is there any defect in:
Sight: _____

Hearing: _____

Speech: _____

Figure: _____

10. Has the pupil been immunised against Diphtheria/Tetanus_____

11. Has the pupil been immunised against Smallpox _____

12. Has the pupil been immunised against Polio _____

13. Immunisation against other diseases: _____

14. Is there any family history of infectious, congenital or hereditary diseases: (e.g. diabetes, Tuberculosis,. Leukaemia, Mental, haemorrhage, defective vision, defective hearing, etc.)

_____

15. What is the pupils general physical build: (weak, good, fair, average, stunted).

_____

16. What is the overall physical health of the pupil: _____
(E.g. ill, healthy, needs constant medical attention, etc.)

17. Height _____ Weight _____

18. REMARKS:

_____

_____

_____

_____

_____

_____ _____
Parental/Legal Guardian. Social Worker.

_____ _____
Date: Date:

MEDICAL DETAILS REGARDING APPLICANT (to be completed by a Medical Practitioner)

NAME: _____

GENDER : _____

DATE OF BIRTH/AGE_____

ADDRESS: _____

1. Are the lungs sound? _____

2. Are the sounds, impulses & rhythm of the heart and circulatory system normal in every respect?

_____

3. Is there a defect in: (a) Sight? _____

(b) Hearing? _____

(c) Speech? _____

(d) Figure? _____

4. Is there any hernia? _____

5. Does he/she suffer from epileptic attacks? _____

6. Are the teeth sound? If not, do they require treatment? _____

7. Is there any sign of appendicitis? _____

8. Is there any tonsil or adenoid defects? _____

9. Is there any sign of venereal disease? _____

10. Is there any sign of diabetes? _____

11. Is he/she apparently free of any infectious or contagious diseases? _____

12. Does he/she suffer from any physical disability which is likely to handicap him/her in the course of training?

_____

13. Do you consider him/her to be mentally normal? _____

14. Is there any family history of mental illness? _____

If so, please give details: _____

15. Does he/she appear capable of benefitting from education and training in a special school for the Blind/Deaf?

_____

16. Were the parents or grandparents related prior to marriage? _____

17. Is there evidence of diabetes in the family? If so, please give details?

18. Any other remarks:

Place: Date:

Signature of Medical Practitioner Stamp

Questionnaire:

ADDENDUM TO FORM I.E. 1

APPLICATION FOR ADMISSION OF PUPIL TO SCHOOL:
IMMUNISATION AGAINST TUBERCULOSIS

1. Has the pupil been immunised against tuberculosis?

2. If not, or if repeat immunistaion against tuberculosis is necessary, do you give permission for your child to be immunised against tuberculosis?

3. If you object to such immunisation, please attach the immunisation card Health 183 which has been endorsed by an immunising officer as laid down I regulate 12 of the regulations published in Government Notice No. R.1754 of September 1973.

PARENT/GUARDIAN

CONSENT AND INDEMNITY

I, _____
(Full Name)
of_____
(Address)
_____

_____

the Parent/Guardian of_____

do hereby give my consent for my child's/ward's participation in all the extra-curricular activities of the above-named School. Including games, educational tours, country, city, and town tours and excursions, provided the School's Medical Officers are of the opinion that such participation will not be to the detriment of the child's/ward's health.

I fully understand and accept that all such tours, excursions and activities shall be undertaken at my child'd/ward's own risk and I undertake, on behalf of myself, my executors, my wife and my above-named child/ward to indemnify, hold harmless and absolve the Department of Internal Affairs, the Principal of the above-named School, his Staff, or any duly-appointed officer against and from any or all claims whatsoever that may arise I connection with any loss of or damage to the property or injury to the person of my above-named child/ward in the course of any such tour, excursion or activity, in the knowledge that the principal and his staff or other duly-appointed officer will, nevertheless, take all reasonable precautions for the safety and welfare of my child/ward.

_____
PARENT/GUARDIAN

Signed at _____

this _____day of _____20_____

Witness: 1. _____

Witness 2. _____

FOR SOCIETY AND SCHOOL'S OFFICIAL USE

A. SOCIETY

1. Parents interviewed: Date:_____
2. Social Worker: _____
3. Parents's consent for school admission: Yes/No: _____ Date:_____
4. Assistance/advice to parents: _____

_____

_____

5. I.B.P. applied for: _____ Date: _____ I.B.P. No.:_____

REMARKS:

_____

_____

_____

_____
NIBS Officer

B. SCHOOL

1. Date pupil interviewed: _____By: _____
2. Date of admission: _____ Std/Class: _____
3. Day/Boarding Pupil: _____
4. Board approval - Date: _____
5. I A D approval - Date : _____Granted: _____
6. Subsidy: _____
7. Other: _____

REFERRALS:

1. Medical: Date : _____
2. Chest X-Ray : _____
3. Otological : _____
4. Psychological : _____
5. Other (inc. Immunisation)_____

EYE REPORT FOR CHILDREN WITH VISUAL PROBLEMS
(To be filled by School Principal/Social Worker)

Name of Pupil (Surname First) : _____
Address:
_____

Gender: _____Date of Birth : _____

Religious denomination : _____

School : _____

Address : _____

Class/Standard : _____

Began School (Year) _____

To be returned as soon as possible to

EYE REPORT FOR CHILDREN WITH VISUAL PROBLEMS
(Confidential - To be filled in by Ophthalmologist)

C. HISTORY

1. Probable age of onset of visual impairment : R.E _____ LE._____

2. Severe ocular infections, injuries, operations, if any, with age at time of occurrence: _____
3. Has Pupils ocular condition occurred in any blood relative/s? _____ If so, state relationship/s: _____

   Were patients' parents blood relatives? _____

D. MEASUREMENTS

1. Visual Acuity:

	DISTANT VISION		**NEAR VISION**		
WITHOUT CORRECTION	WITH CORRECTION	WITH LOW VISION AID	WITHOUT CORRECTION	WITH CORRECTION	WITH LOW VISION AID

2. If any low vision aid is prescribed for educational purposes, specify, type and recommendation for use:

_____

_____

3. Is there Impaired Colour Perception? _____

If so, for what colours? _____

E. CAUSE OF BLINDNESS/ VISION IMPAIRMENT

1. Present ocular condition responsible for vision impairment (if more than one, specily all, but underline the one which probably first caused severe visual impairment).

R.E . _____

L.E. _____

2. Preceding ocular condition, if any, which led to present condition, or to the underlined condition specified in D.1 above:

R.E . _____

L.E. _____

3. Etiology of ocular condition primarily responsible for vision impairment (e.g. specific disease, injury, poisoning, heredity, or other prenatal influence, etc.):

R.E . _____

L.E. _____

4. If etiology is injury or poisoning, indicate briefly the circumstances and kind of object or poison involved:

_____

_____

F. PROGNOSIS AND RECOMMENDATIONS

1. Is pupil's vision impairment considered to be:

Stable? _____ Deteriorating? _____

Uncertain? _____ Capable of Improvement? _____

2. What treatment is recommended, if any?

_____

_____

_____

3. Is re-examination advised? _____ If so, after what interval? _____

4. Glasses: Not needed: _____ To be worn constantly: _____

For close work only: _____

Other (specify): _____

5. Lighting Requirements:
Better than average: _____ Less than average: _____

6. Use of Eyes: Unlimited: _____ Limited, as follows: _____

7. Physical Activity: Unrestricted: _____ Restricted, as follows: _____

8. Pupil should/should not be placed in a school for blind/partially sighted children.

_____

9. Other Recommendations:

_____

_____

_____

_____

Name of Examiner: _____

Degree/s: _____

Address: _____

Date of Examination: _____