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


   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 immunisation 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 in 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’s/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 in 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 Pupil's ocular condition occurred in any blood relative/s? ______________ If so, state relationship/s: ________________________________________________________________

   Were patients' parents blood relatives? ________________________________________________________________

D. MEASUREMENTS

1. Visual Acuity:

<table>
<thead>
<tr>
<th>DISTANT VISION</th>
<th>NEAR VISION</th>
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<tbody>
<tr>
<td>WITHOUT CORRECTION</td>
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<td>WITHOUT CORRECTION</td>
<td>WITH CORRECTION</td>
</tr>
</tbody>
</table>

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, specify 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: __________________________________________________________________