JAMAICA SOCIETY FOR THE BLIND

MEDICAL REPORT

TO BE COMPLETED BY A PHYSICIAN, LICENSED TO PRACTICE MEDICINE IN JAMAICA, TO DETERMINE IF THE CLIENT IS ELIGIBILE TO PARTICIPATE IN THE JAMAICA SOCIETY FOR THE BLIND'S ADJUSTMENT TO BLINDNESS PROGRAMME.

LAST NAME MR. / MRS. / MISS		**FIRST NAME**	
		AGE	
ADDRESS		WEIGHT	
		HEIGHT	
DOES THE APPLICANT HAVE ANY HEART CONDITION?			
BLOOD PRESSURE			
DOES THE APPLICANT HAVE A CONTAGIOUS OR COMMUNICABLE DISEASE?		YES	NO
IF YOUR ANSWER IS YES, PLEASE INDICATE THE NATURE OF THE DISEASE.			
OTHER ABNORMALITIES			

PREVIOUS DISEASE (PLEASE CHECK)		○ ARTHRITIS	○ ASTHMA
○ DIABETES	○ EPILEPSY	○ HAY FEVER	○ JAUNDICE
○ SKIN DISEASE	○ NERVOUS DISORDERS	○ HEARING	
PREVIOUS OPERATION (OTHER THAN THE EYES			

DIET RECOMMENDED	ORDINARY	SPECIAL

<table>
<tr><td colspan="3">IF SPECIAL DIET, PLEASE SPECIFY NATURE THEREOF.</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td>IS TREATMENT OR MEDICATION REQUIRED?</td><td>YES</td><td>NO</td></tr>
<tr><td colspan="3">IF YES, PLEASE STATE THE NATURE THEREOF.</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">EXPECTED SIDE EFFECTS</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td colspan="3">THE REHABILITATION PROGRAMME DOES NOT PROVIDE NURSING CARE. IN YOUR OPINION, WILL THE APPLICANT'S PRESENT PHYSICAL CONDITION ENABLE HIM/HER TO TAKE NORMAL RESPONSIBILITIES FOR HIS/HER OWN CARE?</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td>NAME OF PHYSICIAN</td><td colspan="2"></td></tr>
<tr><td>ADDRESS</td><td colspan="2"></td></tr>
<tr><td>TELEPHONE NUMBER (S)</td><td colspan="2"></td></tr>
<tr><td></td><td>PHYSICIAN'S SIGNATURE</td><td></td></tr>
<tr><td></td><td>DATE</td><td></td></tr>
</table>