ST. SCHOLASTICA'S COLLEGE

2560 Leon Guinto Sr. St.
Malate, Manila

STUDENT HEALTH RECORD

NAME ____
Last *First* *M.I.*

SEX ________ AGE ________ DATE OF BIRTH __________________ NATIONALITY ________________

PRESENT ADDRESS ______________________________ TEL. NO. ________________

PARENT OR GUARDIAN ______________________________ TEL. NO. ________________

ADDRESS ____

Alternate person to be notified in case of emergency ______________________________
______________________________ TEL. NO. ________________

In case of emergency, may the school authorities take you to the nearest hospital before calling parents/ guardian Yes ________ No __________

Blood Type _____________

PAST MEDICAL HISTORY: Check diseases you have had

1. Allergies (specify) ______________________
2. Bronchial Asthma ______________________
3. Bleeding tendencies ______________________
4. Chicken pox ______________________
5. Convulsive disorder ______________________
6. Diabetes Mellitus ______________________
7. Epilepsy ______________________
8. Heart Disorder ______________________
9. Hepatitis A ________________ B _____________
10. German Measles ______________________
11. Kidney disease ______________________
12. Hypertension ______________________
13. Mumps ______________________
14. Psychoneurosis ______________________
15. Tuberculosis ______________________
16. Others (specify) ______________________

IMMUNIZATION RECORD – Check immunizations completed

BCG _____

DPT 1 _____
2 _____
3 _____

Booster 1 _____
2 _____
3 _____

PPD _____

PPD _____

Oral Polio 1 _____
2 _____
3 _____

Booster 1 _____
2 _____
3 _____

MMR _____

Measles _____

Mumps _____

German Measles _____

Cholera _____

Typhoid _____

Hepatitis A 1 _____ B 1 _____
2 _____ 2 _____
3 _____ 3 _____

Chicken pox _____

May any of the following medicines be given as the physical need indicate.

	Yes	No		Yes	No		Yes	No
Paracetamol	____	____	Decolgen	____	____	Midol	____	____
Tempra	____	____	Mefenamic acid	____	____	Bonamine	____	____
Winadol	____	____	Cabocisteine	____	____	Mucilan	____	____
Hydrite	____	____	Ventolin	____	____	Loperamide	____	____
Buscopan	____	____	Chlorphenamine	____	____	Celestamine	____	____

Is there any special condition your child suffers from? Pls. specify.

____

____

____

Any special medication your child need?

____

____

____

Is there any special instructions you want the clinic staff to know or do to your child?

____

____

____

Elder sister in school: ______________________________ ______________________________
(Name) (Gr./Yr. & Sec.)

______________________________ ______________________________
(Name) (Gr./Yr. & Sec.)

Doctors to be notified: ______________________________ Tel. No. ______________

Address: ____

______________________________ ______________________________
Parent Signature Date Filed

PHYSICAL EXAMINATION

Date							
Gr./Yr. & Sec.							
Age							
Height							
Weight							
Nutrition							
Posture							
Deformities							
Skin							
Vision R							
Vision L							
Hearing R							
Hearing L							
Speech							
Eye							
Ear							
Nose							
Tonsils							
Adenoid							
Throat							
Cervical glands							
Breast Mass							
Lungs							
Heart							
Spleen							
Liver							
Skin							
Extremities							
Others:							
Signature of Examiner							

CODE: O – Satisfactory; X – Observation; XX – Requiring treatment; XXX – Immediate action needed;
C – Corrected; UT – Under Treatment

CONSULTATIONS

Date	Complaint and Physical Findings	Treatment	Physician

PHYSICAL EXAMINATION

Date							
Gr./Yr. & Sec.							
Age							
Height							
Weight							
Nutrition							
Posture							
Deformities							
Skin							
Vision R							
Vision L							
Hearing R							
Hearing L							
Speech							
Eye							
Ear							
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Adenoid							
Throat							
Cervical glands							
Breast Mass							
Lungs							
Heart							
Spleen							
Liver							
Skin							
Extremities							
Others:							
Signature of Examiner							

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CONSULTATIONS

Date	Complaint and Physical Findings	Treatment	Physician