STUDENT HEALTH RECORD

PART 1 (To be filled up by the parent)

Name _____ Sex _____
Family Name Given Name Middle Name

Address _____ Tel/Cel No._____
Nationality _____ Birthday_____ Religion_____
Father's Name _____ Occupation_____
Address_____ Tel/Cel No._____
Mother's Name _____ Occupation_____
Address_____ Tel/Cel No._____
Guardian's Name_____ Tel/Cel No._____

Person to call in case of Emergency:_____ Blood type_____
Relation to student _____
Address_____ Tel/Cel No._____

Hospital of choice for referral or admission: _____
Physician _____ Tel/Cel No._____
Address _____

A. Immunization Record

Vaccine	Vaccination Dates	Vaccine	Vaccination Dates
BCG		Hepatitis B I	
DPT/OPV 1		Hepatitis B II	
DPT/OPV II		Hepatitis B III	
DPT/OPV III		MMR	
DPT/OPV booster 1		Chicken Pox 1	
DPT/OPV booster 2		Chicken Pox 2	
HIB I		Hepatitis A I	
HIB II		Hepatitis A II	
HIB III		Hepatitis A III	
Measles		Varicella	
Tetanus Toxoid		Others	
Typhoid Fever			

B. MEDICAL HISTORY

The child has a history of :	No	If Yes pls. specify
Hospitalization		
Surgery/operation		

The child has suffered from: (please check No or Yes)

Illness	NO	YES	Illness	No	Yes	Illness	No	Yes
Allergy			Eye problem			Measles		
Anemia			Fainting			Mumps		
Asthma			Fracture			Parasitism		
Behavior Problem			Hearing problem			Pneumonia		
Bleeding Problem			Heart Disorder			Primary Complex		
Chicken Pox			Hyperacidity			Skin Problem		
Convulsion			Indigestion			Speech Problem		
Dengue			Insomnia			Spine disorder		
Diabetes			Intestinal Worms			Tonsillitis		
Ear Problem			Kidney Disease			Typhoid Fever		
Eating Disorder			Liver Disease			Vision Defect		
Epilepsy			Lung Disease			Others (pls. specify)		

For Boys: Circumcision: _____ Done _____ Not done

For Girls: Menstrual history

Age of menarche: _____ Last menstrual period _____
Cycle: Regular: _____ Irregular _____
Flow: Minimal: _____ Moderate_____ Profuse_____

C. FAMILY HISTORY

Disease	No	Yes	Relation(s)to child	Disease	No	Yes	Relation(s) to child
Asthma				Kidney Problem			
Bleeding Tendency				Mental Disorder			
Cancer				Obesity			
Diabetes				Seizure Disorder			
Epilepsy				Stroke			
Heart Disorder				Tuberculosis			
High Blood Pressure							

D. ALLERGIES and MEDICATIONS

Important questions to answer:	No	If Yes, please specify…
Is the student taking any special medication? (If yes, please specify what medicine including the dosage)		
Is the student having allergy to medicines? (If yes, please specify what medicines)		
Is the student having allergy to a certain food?		
Is the student having a special medical condition? (If yes, please provide a copy of the medical certificate from the attending physician)		

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Signature Over Printed Name of Parent