Assumption College
San Lorenzo
BASIC EDUCATION DIVISION

STUDENT HEALTH RECORD

This portion is to be filled up by parent(s) / guardian(s)

GENERAL DATA

Family Name	*Middle Name*		*Nationality*
Given Name			*Birthday (mm/dd/yyyy)*
Religion			*Birthplace*
Address			*Landline*
Mother		*Age*	*Occupation*
Contact Nos. *Office*	*Cellphone No.*		
Father		*Age*	*Occupation*
Contact Nos. *Office*	*Cellphone No.*		
Guardian		*Age*	*Occupation*
Contact Nos. *Office*	*Cellphone No.*		
In case of emergency, notify (in the absence of parent(s)/guardian)			*Contact Nos.*

FAMILY HISTORY

Disease	***No***	***Yes***	***Relation***	***Disease***	***No***	***Yes***	***Relation***
Cancer				Asthma			
Heart problem				Bleeding problem			
Hypertension				Mental trouble			
Diabetes				Learning Disabili			
Tuberculosis				Others			
Convulsions							

PAST MEDICAL HISTORY (Has the child suffered from any of the following)

Disease	***No***	***Yes***	***Disease***	***No***	***Yes***	***Disease***	***No***	***Yes***
Allergy			Chicken Pox			Heart disease		
Bronchial asthma			Dengue fever			Kidney disease		
Anemia			Typhoid fever			Convulsion		
Bleeding problem			Measles			Epilepsy		
Behavioral problem			Mumps			Diabetes		
Hearing problem			Pneumonia			Fainting Spells		
Speech problem			Primary Complex			Fractures		
Visual problem			Ear discharge			Hospitalization		
Recurrent indigestion			Tonsillitis			Operation/Others		

If answer is YES, please give relevant details:

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OTHER INFORMATION:

Any special MEDICATION?	Allergy to MEDICINES?
Requires SPECIAL CARE?	Others:

Questionnaires answered by:

______________________	______________________	______________________
(Signature over printed name)	*Relation to student*	*Date Accomplished*

Assumption College
San Lorenzo
BASIC EDUCATION DEPARTMENT

STUDENT HEALTH RECORD

(This portion is to be filled up by your family physician / pediatrician)

IMMUNIZATION

Vaccine	*Date(s) Given*	*Vaccine*	*Date(s) Given*
BCG		MMR 1	
DPT 1		2	
2		Typhoid 1	
3		2	
Booster 1		3	
2		Hepatitis A 1	
OPV 1		2	
2		3	
3		Hepatitis B 1	
Booster 1		2	
2		3	
HIB 1		4	
2		Chicken Pox	
3		Others:	
4			
Measles			

PHYSICAL EXAMINATION

Heart Rate		Respiratory Rate		Temperature	
Weight		Height		Blood Pressure	

Check N if Normal and A if any abnormality found. Specify.

	N	*A*	*Abnormality*		*N*	*A*	*Abnormality*
Skin				Chest			
Eyes				Lungs			
Ears				Heart			
Nose				Abdomen			
Mouth				Rectum			
Pharynx				Genitalia			
Tonsils				Spine			
Gums				Arms			
Lymph Nodes				Legs			
Neck				Feet			

ASSESMENT:

Essentially Normal Physical Examination Findings

With limitation of activities as:

Requires special attention

Examining Physician ____________________

Signature ____________________

License No. ____________________

Date ____________________