St. Scholastica's College

2560 Leon Guinto Sr. St., Malate, Manila

COLLEGE STUDENT HEALTH RECORD

NAME_____
Last *First* *M.I.*

SEX _____ AGE _____ DATE OF BIRTH _____ ___, _____NATIONALITY_____

PRESENT ADDRESS _____

PARENT/GUARDIAN _____TEL/MOBILE NO._____

ADDRESS (if not the same w/ present address) _____

Alternate person to be notified in case of emergency_____

Relationship to student_____Tel/Mobile No._____

In case of emergency, may the school authorities take you to the nearest hospital before calling parent/guardian? Yes____

If **NO**, Doctor to be notified_____Tel/Mobile No._____

Hospital Affiliation_____Telephone No. _____

Do you have any special conditions that the school needs to be aware of? No ____ If **YES**, please specify_____

_____

PAST MEDICAL HISTORY (Check diseases you have had and indicate age/year of condition.)

- ☐ Allergies (***Specify)*** _____
- ☐ Bronchial Asthma _____
- ☐ Bleeding tendencies_____
- ☐ Chicken pox_____
- ☐ Convulsive disorder_____
- ☐ Diabetes mellitus_____
- ☐ Epilepsy_____
- ☐ Heart disorder_____
- ☐ Hepatitis A _____ B_____
- ☐ German Measles_____
- ☐ Kidney disease_____
- ☐ Hypertension_____
- ☐ Mumps_____
- ☐ Psychoneurosis_____
- ☐ Tuberculosis_____
- ☐ Others (specify)

_____

IMMUNIZATION RECORD (Check immunizations completed)

- ☐ BCG
- ☐ DPT 1 __ 2 __ 3 __
- ☐ DPT Booster
- ☐ PPD
- ☐ Chicken Pox
- ☐ Oral Polio (OPV) 1 __ 2 __ 3 __
- ☐ OPV Booster
- ☐ MMR (measles, mumps, rubella)
- ☐ German Measles
- ☐ Cholera
- ☐ Typhoid
- ☐ Hepatitis A 1__ 2 __ 3 __
- ☐ Hepatitis B 1 __ 2 __ 3 __

_____ _____

Student's Signature ***Date***

----------***To be filled up by the school clinic personnel only***----------

DRUG TEST

Date Taken						
Result						
Agent						

CHEST XRAY

Date Taken						
Result						
Agent						
Film #						

PHYSICAL EXAMINATIONS

Date								
Course								
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: LMP								
Signature of Examiner								

CODE:
O – Satisfactory
C – Corrected
X – Observation
XX – Requiring Treatment
UT – Under Treatment

STOOL EXAM (For HRM students only)

Date Taken						
Result						
Agent						

CONSULTATIONS

Date	Complaint and Physical Findings	Treatment	Physician