St. Scholastica's College

2560 Leon Guinto Sr. St., Malate, Manila

1 x 1 Photo

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 your child to the nearest hospital before calling parent/guardian? Yes ____ If **NO**,

Doctor to be notified _____Tel/Mobile No. _____

Hospital Affiliation _____Telephone No. _____

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
- ☐ German Measles
- ☐ Cholera
- ☐ Typhoid
- ☐ Hepatitis A 1__ 2 __ 3 __
- ☐ Hepatitis B 1 __ 2 __ 3 __

PARENT(S)/GUARDIAN(S) STATEMENT

I give my permission to examine and administer medications as prescribed by the school health authorities to my child as deemed necessary. I understand that the ***medications and first aid treatment*** will be provided for which I allow below.

- ☐ Paracetamol (Biogesic/Tempra)
- ☐ Hydrite
- ☐ Buscopan
- ☐ Decolgen (No Drowse)
- ☐ Mefenamic Acid (Ponstan)
- ☐ Carbocisteine
- ☐ Salbutamol (Ventolin)
- ☐ Plasil
- ☐ Bonamine
- ☐ Kremil S/Maalox
- ☐ Loperamide
- ☐ Celestamine/Loratadine
- ☐ Relestal
- ☐ Strepsils
- ☐ Spirit of Ammonia
- ☐ Others_____

- ☐ Betadine
- ☐ Fucithalmic (eye ointment)
- ☐ Bactroban (antibiotic)
- ☐ Flammazine
- ☐ Vandol
- ☐ Hydrocortisone
- ☐ Visine
- ☐ Synalar
- ☐ Hydrogen Peroxide
- ☐ Betadine Paint (oral)
- ☐ Caladryl
- ☐ Salonpas Gel
- ☐ Vicks
- ☐ White Flower
- ☐ Petroleum Jelly

Is there any special condition your child suffers from? (Specify)

_____

Please list any substances/medicines your child is allergic to.

_____

_____ _____

Parent/Guardian Signature above Printed Name ***Date***

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

CHEST XRAY (*For **High School students** only*)

Date Taken						
Result						
Agent						
Film #						

PHYSICAL EXAMINATIONS

Date								
Gr/Yr/Section								
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								