HEALTH SERVICES DEPARTMENT
MEDICAL FORM
S.Y. 20__-20__

PERSONAL DATA:

Student's Name: _____
(Last Name) *(First Name)* *(Middle Name)*

Complete Home Address: _____

_____

Grade Level & Section: _____ Birthday: _____ Gender: _____

Person to contact in case of emergency:

Name: _____ Relation to the Student: _____

Contact Details:(mobile number) _____ (landline) _____

HEALTH DATA:

Previous illness: (please check all that applies)

[ ] Asthma [ ] Chicken Pox [ ] Mumps [ ] Urinary Disorder
[ ] Tuberculosis [ ] Measles [ ] Diabetes [ ] Seizure Disorder
[ ] Pneumonia [ ] Typhoid Fever [ ] Hypertension/Heart Disease
[ ] Others (*please specify*): _____

Did the child undergo any operation?

[ ] Yes (*please specify the nature and date of operation*): _____
[ ] No

_____
Signature over printed name of parent/guardian

Present illness:

Does the child have any present illness? (please specify): _____
Maintenance medication if any (please specify the name & dosage): _____
Does the child have any allergies? (please specify the name & dosage): _____
Does the child have visual/hearing impairment? (please specify): _____
Does the child have any restrictions to participate in physical activities? (please specify):

_____

**Please attach medical certificate if the child has present medical conditions that require attention*

IMMUNIZATION RECORD:

TYPE		DATE/S
DPT & Polio	3 doses + 3 booster dose	
BCG	At birth (0-1 months)	
MMR	1 dose at 15 months old & at 4 years old and above	
Influenza	Recommended at 6-23 months old & yearly thereafter	
Anti Cervical Cancer	At 9 years old and above 3 doses	
Typhoid	Single dose as early as 2 years old	
Tetanus	Between ages 12-15 years	
Hepatitis A	At 12 months – 2 doses 6 months apart	
Hepatitis B	At birth + 3 doses	
Varicella (Chicken Pox)	At 12 months old	

Remarks: _____

I hereby certify that the student is fit for school.

_____ _____ _____
Signature above printed name of physician Licensed Number Date