

ST. MARY'S COLLEGE OF BALIUAG
STUDENT'S HEALTH RECORD

(To be filled up by parent / guardian)

Incoming grade level _____

Name _____ **Birthday** _____

Address _____ **Contact no.** _____

Nationality _____ **Age** _____ **Gender** _____ **Religion** _____

Father's Name _____ **Occupation** _____

Address _____ **Contact no.** _____

Mother's Name _____ **Occupation** _____

Address _____ **Contact no.** _____

Person to Contact in Case of Emergency _____ **Contact no.** _____

Address _____ **Relation to student** _____

Other means / ways to contact you in case of emergency _____

Hospital of Choice for Referral _____ **Contact no.** _____

Physician _____ **Contact no.** _____

A. MEDICAL HISTORY: Please check (yes) if the child has suffered from the following health conditions:

ILLNESS	NO	YES	ILLNESS	NO	YES	ILLNESS	NO	YES
Allergy			Eye/ Vision Defect			Nose Bleeding		
Anemia			Fainting			Parasitism		
Asthma			Fracture			Pneumonia		
Behavioral Problem			Heart Disease			Primary Complex		
Bleeding Problem			Hyperacidity			Rheumatic Fever		
Chicken Pox			Indigestion			Skin Problem		
Convulsion			Kidney Problem			Speech Disorder		
Dengue			Liver Disease			Spine Problem		
Diarrhea			Lung Disease			Tonsillitis		
Ear /Hearing Defect			Measles			Typhoid Fever		
Eating Disorder			Mumps			UTI		

B. FAMILY HISTORY

DISEASE	NO	YES	RELATION TO STUDENT
Asthma			
Bleeding Tendency			
Cancer			
Diabetes			
Heart Disease			
High blood Pressure			
Kidney Problem			
Mental Disorder			
Obesity			
Seizure Disorder			
Stroke			
Tuberculosis			

Please continue at the back

NEW STUDENT

ST. MARY'S COLLEGE OF BALIUAG
STUDENT'S HEALTH RECORD

(To be filled up by parent / guardian)

Incoming grade level _____

Name _____ **Birthday** _____

Address _____ **Contact no.** _____

Nationality _____ **Age** _____ **Gender** _____ **Religion** _____

Father's Name _____ **Occupation** _____

Address _____ **Contact no.** _____

Mother's Name _____ **Occupation** _____

Address _____ **Contact no.** _____

Person to Contact in Case of Emergency _____ **Contact no.** _____

Address _____ **Relation to student** _____

Other means / ways to contact you in case of emergency _____

Hospital of Choice for Referral _____ **Contact no.** _____

Physician _____ **Contact no.** _____

A. MEDICAL HISTORY: Please check (yes) if the child has suffered from the following health conditions:

ILLNESS	NO	YES	ILLNESS	NO	YES	ILLNESS	NO	YES
Allergy			Eye/ Vision Defect			Nose Bleeding		
Anemia			Fainting			Parasitism		
Asthma			Fracture			Pneumonia		
Behavioral Problem			Heart Disease			Primary Complex		
Bleeding Problem			Hyperacidity			Rheumatic Fever		
Chicken Pox			Indigestion			Skin Problem		
Convulsion			Kidney Problem			Speech Disorder		
Dengue			Liver Disease			Spine Problem		
Diarrhea			Lung Disease			Tonsillitis		
Ear /Hearing Defect			Measles			Typhoid Fever		
Eating Disorder			Mumps			UTI		

B. FAMILY HISTORY

DISEASE	NO	YES	RELATION TO STUDENT
Asthma			
Bleeding Tendency			
Cancer			
Diabetes			
Heart Disease			
High blood Pressure			
Kidney Problem			
Mental Disorder			
Obesity			
Seizure Disorder			
Stroke			
Tuberculosis			

Please continue at the back

C. IMMUNIZATION HISTORY

VACCINE	DATE GIVEN	VACCINE	DATE GIVEN	VACCINE	DATE GIVEN	VACCINE	DATE GIVEN
BCG		DPT/OPV booster 2		MMR Measles,Mumps,Rubella)		Varicella 2 (Chicken Pox)	
DPT/OPV I		Hib I		Hepatitis B I		Hepatitis A I	
DPT/OPV II		Hib II		Hepatitis B II		Hepatitis A II	
DPT/OPV III		Hib III		Hepatitis B III		Flu	
DPT/OPV booster 1		Measles		Varicella 1(Chicken Pox)		Typhoid Fever	
Others:							

SpecialMedication_____Food/DrugAllergy_____

Other Relevant Health Information_____

INFORMANT: _____
Signature over printed name

C. IMMUNIZATION HISTORY

VACCINE	DATE GIVEN	VACCINE	DATE GIVEN	VACCINE	DATE GIVEN	VACCINE	DATE GIVEN
BCG		DPT/OPV booster 2		MMR Measles,Mumps,Rubella)		Varicella 2 (Chicken Pox)	
DPT/OPV I		Hib I		Hepatitis B I		Hepatitis A I	
DPT/OPV II		Hib II		Hepatitis B II		Hepatitis A II	
DPT/OPV III		Hib III		Hepatitis B III		Flu	
DPT/OPV booster 1		Measles		Varicella 1(Chicken Pox)		Typhoid Fever	
Others:							

SpecialMedication_____Food/DrugAllergy_____

Other Relevant Health Information_____

INFORMANT: _____
Signature over printed name