

OLD STUDENT

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

(To be filled up by parent / guardian)

Incoming grade / year level _____

Name of student _____ Birthday _____

Parent(s)/ Guardian _____ Contact no. _____

Address _____ Contact no. _____

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

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

Hospital of Choice for Referral _____ Contact no. _____

A. MEDICAL HISTORY: Please update the health history of your child:

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			

Please continue at the back**OLD STUDENT**

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Address _____ Contact no. _____

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Hospital of Choice for Referral _____ 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			

Please continue at the back

C. IMMUNIZATION HISTORY (Please check whether the following vaccines were received by your child)

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 (Please check whether the following vaccines were received by your child)

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