MIRIAM COLLEGE
MIDDLE SCHOOL

2 x 2
photo

STUDENT HEALTH RECORD FORM

NAME: _____ _____ _____ _____
Last First Middle Nickname

ADDRESS: _____ TEL NO. _____
_____ BIRTHDAY: _____

FATHER'S NAME: _____ MOTHER'S NAME: _____
OCCUPATION: _____ OCCUPATION: _____
BUSINESS ADDRESS: _____ BUSINESS ADDRESS: _____
TEL. NUMBER(S): _____ TEL. NUMBER (S): _____
MOBILE NO: _____ MOBILE NO: _____

STUDENT FREQUENTLY HAD: (Please check)

_____Abdominal pain _____Fever
_____Backache _____Headache
_____Chest pains _____Easy fatigability
_____Colds _____Nose Bleeding
_____Cough _____Sore throat
_____Dizziness _____Others (specify): _____

PAST DISEASE: (please check)

_____Allergy _____German Measles _____Tonsillitis
_____Asthma _____Mumps _____Bleeding Tendencies
_____Convulsions _____Whooping cough _____Joint swelling
_____Chickenpox _____Urinary trouble _____Heart trouble
_____Diphtheria _____Rheumatic fever _____Worms
_____Hepatitis _____Primary complex _____Operations
_____Measles _____Typhoid _____Injuries

FAMILY DISEASE: (please check)

_____Cancer _____Heart disease _____Peptic ulcer
_____Diabetes _____High blood pressure _____Tuberculosis
_____Epilepsy _____Nervous breakdown _____Others (specify)

DRUG PREPARATION GIVEN TO CHILD IN CASE OF:

Fever _____ Eye Problem _____
Abdominal Pain _____ Cough & Colds _____
Headache _____ Dizziness _____
Others _____ _____

We acknowledge the protocols of the school in communicating with parents, administering first aid, addressing emergency treatment, transporting to the nearest hospital that can provide the necessary medical management, and acquiring medical clearance when returning back to school after an injury or communicable disease.

IMMUNIZATION

VACCINE	DATE(S)GIVEN	VACCINE	DATE(S) GIVEN
BCG		MMR 1	
DPT 1		2	
2		Typhoid 1	
3		2	
Booster 1		3	
2		Hepatitis A 1	
Poliomyelitis/OPV 1		2	
2		3	
3		Hepatitis B 1	
Booster 1		2	
2		3	
HIB 1		4	
2		Chickenpox	
3		Others:	
4			
Measles			

Please check and note if the child:

_____ has any special medication : _____
_____ requires special care : _____
_____ is allergic to any drug preparation : _____
_____ has requests : _____
_____ others : _____

IN CASE OF EMERGENCY (ACCIDENT OR ILLNESS) AND PARENTS CANNOT BE REACHED BY PHONE, ALTERNATE PERSONS TO BE NOTIFIED ARE:

1. _____ Tel. No. _____
2. _____ Tel. No. _____

DOCTOR TO BE NOTIFIED: _____ Tel. No. _____

CERTIFIED CORRECT:
NAME OF FAMILY PHYSICIAN _____
PRC NO. _____ SIGNATURE _____

SIGNATURE OF PARENT/GUARDIAN: _____
DATE: _____

MIRIAM COLLEGE
MIDDLE SCHOOL

NAME: _____

	Grade 6	Grade 7	Grade 8	REMARKS
DATE				
SECTION				
AGE				
Height				
Weight				
Vision R.				
Vision L.				
Pediculosis				
Eye				
Ear				
Nose				
Teeth				
Tonsils				
Throat				
Cervical Glands				
Skin				
Cleanliness				
Nutrition				
Posture				
Deformities				
Thyroid gland				
Adenoids				
Lungs				
Heart				
Spleen				
Doctor's Name				
PRC No.				
Doctor's Signature				

CODE O-Satisfactory; XX-requiring attention

Important Note to Parents:
The Annual Physical Exam (APE) is required upon the initial entry level of students (incoming Grade 1 and all new applicants of other grade levels), indicated by the family physician under the corresponding column.