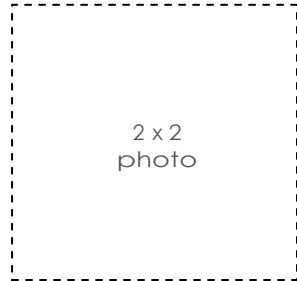




MIRIAM COLLEGE  
MIDDLE SCHOOL



**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 \_\_\_\_\_

**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: \_\_\_\_\_

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.



# MIRIAM COLLEGE MIDDLE SCHOOL

NAME: \_\_\_\_\_

|                           | Grade 6 | Grade 7 | Grade 8 | REMARKS |
|---------------------------|---------|---------|---------|---------|
| <b>DATE</b>               |         |         |         |         |
| <b>SECTION</b>            |         |         |         |         |
| <b>AGE</b>                |         |         |         |         |
| 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                    |         |         |         |         |
|                           |         |         |         |         |
|                           |         |         |         |         |
| <b>Doctor's Name</b>      |         |         |         |         |
| <b>PRC No.</b>            |         |         |         |         |
| <b>Doctor's Signature</b> |         |         |         |         |

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.