Espiritu Santo Parochial School of Manila, Inc.

1912 Rizal Avenue, Sta. Cruz, Manila 1014

MEDICAL RECORD

STUDENT HEALTH INFORMATION

(To be filled up by Parent or Family Physician)

Name of Student_____ Grade/Year & Section_____
Date of Birth_____ Gender_____
Name of Parent/ Guardian_____ Occupation_____
Address_____ Contact Number_____

MEDICAL HISTORY

CHECK IF THE STUDENT HAS HAD/ DOES HE or SHE HAVE FREQUENT

	Measles		Heart Trouble		Headache
	Mumps		Kidney Trouble		Menstrual Cramps
	Pertussis		Eye Complaint		Abdominal Pain
	Asthma		Stomach Upset		Allergies (Specify)
	Chicken Pox		Nose Bleeding		Food: _____
	Convulsion		Dizziness		Medicines: _____

IMMUNIZATION RECORD

Name of Vaccine	Date Given	Name of Vaccine	Date Given
BCG		OPV	
DPT		CHICKEN POX VACCINE	
HEPATITIS A		MMR	
HEPATITIS B		OTHERS (SPECIFY)	

Is there any special condition your child suffer from or any special medications your child needs?
Specify_____

IN CASE OF EMERGENCY IF PARENTS CANNOT BE REACHED
Alternate person to be notified_____ Contact No._____
Preferred Hospital_____ Contact No._____
Hospital Address_____
If emergency treatment is necessary, may the school authorities take the child to the nearest doctor or hospital before calling the parents? _____ YES _____ NO

_____
SIGNATURE OF PARENT OR GUARDIAN
OVER PRINTED NAME