STUDENT MEDICAL RECORD FORM

Please fill out this form completely and accurately. Submit to the School Nurse.

PERSONAL INFORMATION

STUDENT ID NUMBER:	PROGRAM:
LAST NAME:	NICKNAME:
GIVEN NAME:	BLOOD TYPE:
MIDDLE NAME:	

BIRTH DATE (mm/dd/yyyy):	AGE:
BIRTH PLACE:	SEX:
NATIONALITY:	RELIGION:
MOBILE NUMBER:	CIVIL STATUS:
EMAIL ADDRESS:	PHONE NUMBER:
HOME ADDRESS:	

PERSON TO NOTIFY IN CASE OF EMERGENCY

COMPLETE NAME:	EMAIL ADDRESS:
RELATIONSHIP:	HOME ADDRESS:
CONTACT NUMBER:	

PHYSICAL ASSESSMENT

Date of examination:

Height: _____________ Weight: ____________ BMI: ________ BP: __________ Pulse: ___________

COVID-19 VACCINATION

DOSE NUMBER	DATE OF VACCINATION	VACCINE NAME

COVID-19 BOOSTER

BOOSTER NUMBER	DATE OF BOOSTER	BOOSTER NAME

CURRENT CONDITION/S (Please put a ✓ if you have any of these conditions)

	Asthma		Anemia		Seizures		Developmental Delay
	Allergy		Fainting Spells		Heart Condition		Physical Disabilities (Please specify)
	Mental Illness (Please specify)_________________				Others (Please specify)____		

ALLERGIES (Please put a ✓ if you have any of these conditions)

	Food (Please specify)
	Medicines (Please specify)
	Others

CURRENT MEDICATION/S

	Vitamins
	Antibiotics
	Other Maintenance Drugs (Please Specify)

VICES (Please put ✓ if you have any of these vices)

	Smoking		< 5 sticks a day		< 1 pack a day		>1 pack a day		
	Alcohol Drinking		Occasionally		1-2 times a month		Weekly		2-3 times a day

PAST MEDICAL HISTORY (Please put a ✔️ if you have any of these conditions)

	Asthma		Diphtheria		Malaria		Pertussis		Tetanus
	Chicken pox		Fracture		Measles		Primary Complex		Typhoid
	Dengue		Hepatitis		Mumps		Rubella		Others:_______________
Have you ever been hospitalized?					Yes		No		
Have you ever had any surgeries?					Yes		No		

IMMUNIZATIONS (Please put a ✔️ if you've been immunized)

	BCG		Hepatitis B		MMR		Cholera
	DPT-OPV		Measles		Typhoid		Anti-flu (Date of last shot:___________________)

DRUG USE

Do you use marijuana or recreational drugs?		Yes		No
Do you ever used needles to inject drugs?		Yes		No

TATTOO

Do you have a tattoo?		Yes		No
When was the last time you were tattooed?				

EXERCISE

Do you exercise regularly?		Yes		No	How long?	
What kind?				How often?		

SEXUAL ACTIVITY

Are you sexually active?		Yes		No	
Are you using any birth control method?		Yes		No	What kind?:________________________

I hereby certify that all the information mentioned above is true and accurate to the best of my knowledge.

____
Signature of Student/Guardian over printed name

*If the student is 17 years old and below, a parent's or legal guardian's signature is required.