No. _____

STUDENT'S HEALTH INFORMATION SHEET

_____ School Year _____

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** The information on this form will be treated as confidential.*

Part I - To be completed by parent / guardian.

Please answer the information requested and the health history questions about your child.

STUDENT AND FAMILY INFORMATION

Student's Name (according to Birth Certificate)

Last Name	First Name	Middle Name	Chinese Name

Gender _____ Age by JULY _____ Eldest in SJCS _____

Date of Birth _____ Place of Birth _____

Citizenship _____ Religion _____

Home Address _____

Home Phone Number/s _____

	Father	Mother
English Name		
Office Phone Number/s		
Mobile Number/s		
Email Address		
SJCS Alumnus? Batch?		

Guardian's Name _____ Relation _____

Home Address _____

Home Phone Number/s _____ Mobile Number/s _____

Office Phone Number/s _____ Email Address _____

Brothers and sisters (list down from eldest to youngest including the applicant)

Name	Age	School/Company	Yr. Level & Sec./Position

EMERGENCY CONTACT INFORMATION

In the event of an emergency and the parents cannot be reached, please contact any of the following:

Primary Contact _____ Relation _____

Home Phone Number/s _____ Mobile Number/s _____

Office Phone Number/s _____ Email Address _____

Secondary Contact _____ Relation _____

Home Phone Number/s _____ Mobile Number/s _____

Office Phone Number/s _____ Email Address _____

Attending Physician or Health Care Provider _____

Office Phone Number/s _____ Mobile Number/s _____

FAMILY HISTORY

Please check if any member of your family has or had any of the following:

( ) Allergy to food	( ) Allergy to medication	( ) Bronchial asthma	( ) Skin asthma
( ) Birth defects	( ) Bleeding disorder	( ) Migraine	( ) Convulsion/Seizure
( ) Stroke	( ) Heart Disease	( ) Diabetes Mellitus	( ) Hypertension
( ) Cancer	( ) Tuberculosis	( ) Kidney disease	( ) Depression/Anxiety

HEALTH HISTORY

Please check if the child has or had any of the following:

SKIN	Yes	RESPIRATORY	Yes	GENITOURINARY	Yes	INFECTIOUS	Yes
Acne vulgaris		Bronchial Asthma		Kidney/bladder disease		Chickenpox	
Psoriasis		Bronchitis		Urinary tract infection		Measles	
Scabies		Pneumonia				Mumps	
Atopic Dermatitis		Primary Complex or Koch's		**MUSCULOSKELETAL**		German measles	
Other skin problem				Bone/joint pains		Malaria	
		CARDIAC		Fractures/dislocations		Dengue Fever	
EYES		Heart murmur		Back/disc problem		Meningitis	
Blindness		History of chest pain		Scoliosis		Hand, foot & mouth	
Color blindness		History of palpitation		Deformities		disease	
Eye injury / Disease		Heart disease		Muscular disease		Typhoid fever	
		Irregular heart rate					
EARS/NOSE/THROAT		High blood pressure		**ENDOCRINE**		**OTHERS**	
Frequent nosebleed				Diabetes mellitus		Frequent headache	
Frequent ear infection		**GASTROINTESTINAL**		Weight problem		ADHD / ADD	
Hearing loss/defect		Stomach problem/ulcer		Thyroid disease		Speech disorder	
Sinus infection		Hepatitis				Fainting/dizziness	
Perforated eardrum		Irritable bowel problem		**HEMATOLOGIC**		Head injury	
Frequent tonsillitis		Requires special diet		Bleeding disorder		Sleeping disorder	
History of surgery		Had surgery		Anemia		Kawasaki disease	

Please provide details for any 'yes' answers to the above items.

Has your child been diagnosed/assessed to have special needs? _____

If 'yes', please describe and indicate the name of the doctor/developmental pediatrician and his/her contact number.

(Kindly submit a copy of the evaluation.)

Has your child been recommended for therapy by a professional? _____ If 'yes', please specify.

Has your child undergone or is currently undergoing therapy? _____ If 'yes', please specify.

Does your child have any restrictions on physical activites? If 'yes', please specify.

Is he/she presently on any medications? If yes, please indicate in the following table provided.

Name of Medicine	Preparation	Dosage	Frequency

CONSENT FOR TREATMENT

We hereby authorize the health care provider of Saint Jude Catholic School Medical and Dental Clinic to provide medical treatment and services our son/daughter as they deem appropriate while he/she is a student in this institution. This would include referral to the nearest hospital should it be necessary and we are unable to be reached.

Father's Signature	Mother's Signature	Guardian's Signature	Date

Part II - MEDICAL EVALUATION

Mandatory for school admission to be completed and signed by a Licensed Physician.

Student's Name: _____ Date of Birth: _____

Date of Check-up/Physical Examination: _____

( ) I have reviewed the health history information provided by the parent/guardian in the first part of this form.

Height (cm) _____ Weight (kg) _____ BMI _____

Blood Pressure _____ / _____ Pulse Rate _____ / min

Vision Screening:

	Right	Left
Without glasses	20 /	20 /
With glasses	20 /	20 /

( ) Referral made

Auditory Screening:

Right	Left
( ) Pass	( ) Pass
( ) Fail	( ) Fail

( ) Referral made

	Normal	Abnormal
Eyes		
Ears		
Nose		
Throat		
Teeth		
Neck		
Lung		
Heart		

	Normal	Abnormal
Abdomen		
Genitalia		
Posture		
Joints		
Skin		
Neurological		
Behavioral		
Emotional		

Describe Findings:

Comments:

IMMUNIZATION RECORD

*** The immunizations below are mandatory and must be current before a student is admitted to SJCS.**

*** Please indicate the date under the 'dose #' column.**

TYPE OF VACCINE	DOSE 1	DOSE 2	DOSE 3	DOSE 4	DOSE 5
Bacille Calmette Guerin (BCG)					
Hepatitis A					
Hepatitis B					
Oral Poliovirus (OPV) / Inactivated Poliovirus (IPV)					
Diphtheria, Pertussis, Tetanus (DPT)					
Haemophilus Influenza Type B Conjugate (Hib)					
Measles, Mumps, Rubella (MMR)					
Pneumococcal Conjugate Vaccine (PCV)					
Pneumococcal Polysaccharide Vaccine (PPSV)					
Varicella					
Typhoid					
Meningococcal					
Influenza (Flu)					
Tetanus Toxoid					
Human Papillomavirus (HPV)					
Others (Please specify)					

RECOMMENDATION FOR PHYSICAL ACTIVITIES

This student may:

( ) participate fully in the school's Physical Education Program

( ) participate in the school's Physical Education Program with the following restrictions:

_____

_____

_____

This student may:

( ) participate fully in athletic activities and competitive sports

( ) participate fully in athletic activities and competitive sports with the following restrictions:

_____

_____

_____

Status of Student's Health ( ) Excellent ( ) Good ( ) Poor Comment _____

I have reviewed and completed the Health Record of this child.
Likewise, I am confirming the accuracy of the data contained in this form.

_____	_____	_____
Signature over printed name of Physician	Clinic/Hospital Address & Contact #	Date
_____	_____	_____
Signature over printed name of Parent/Guardian	Relationship	Date