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Saint Mary's Angels College of Valenzuela

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CLINIC DEPARTMENT
STUDENT HEALTH PROFILE S.Y. 2022-2023

A. PERSONAL INFORMATION AND DETAILS				
Name: (Last name) (First Name) (Middle Initial)			Level/Section :	
Address :				
Contact Numbers: (mobile/landline number):	Date of Birth	Age :	Height: (in ft.)	Weight: (kg.)
Name of Mother:	Occupation:		Contact number:	Email:
Name of Father:	Occupation:		Contact number:	Email:
B. CONTACT PERSON IN CASE OF EMERGENCY				
Name of Contact Person: (Last name) (First Name) (Middle Initial)			Relationship :	Contact No. :
C. HEALTH AND SAFETY CONDITIONS				
1. Is your child subject to seizures, fainting, epilepsy, bleeding, asthma or any other condition that may affect his or her safety?			(YES)	(NO)
If YES Please specify details			Name of Drug/ Medication Use	

2. Is your child allergic to the following?	If yes, please specify details
☐ Food	
☐ Insect Bite	
☐ Medication	
☐ Others	

D. MEDICATIONS	
1. Is your child had any specific medicine to take for his/her health condition? ☐ Yes ☐ No	Please indicate name of medicine, dosage, and no.of times taken
☐ Vitamins	
☐ Medication for Allergy	
☐ Medication for Asthma	
☐ Medications for present/past illness/sickness	
☐ Others	

E. MEDICAL HISTORY (PAST/ PRESENT ILLNESS &SICKNESS)

HEALTH CONDITION	**YES**	**NO**	Please specify details
Asthma			
G6PD Deficiency			
Stomach Problems (pain, constipation, ulcer or bloated)			
Diabetes			
Lung Problem (Tuberculosis, Bronchitis, & Pneumonia)			
Heart Disorder			
Urinary tract infection (UTI)			
Fainting/Dizziness			
Eye Problem (astigmatism, near/far sighted)			
Fracture (arm, foot, hips, or legs)			

HEALTH CONDITION	YES	NO	Please specify details
Allergic Rhinitis			
Eczema (Skin diseases)			
Febrile Seizures			
Dengue			
Pneumonia			
Hand. Foot and Mouth Disease (HFMD)			
Chickenpox			
Measles			
Is your child wearing an eyeglass?			If yes, indicate the ff: Right eye grade: _____ Left eye grade : _____
Hearing Difficulty			
Other Active Medical Conditions			Please specify diagnosis, state of illness, and any ongoing medications:

F. IMMUNIZATION AND VACCINES (Please attach a copy of immunization record if available)	YES	NO
Is your child completed the basic immunization from birth to 4 years old?		
Hepatitis B		
DtaP (Diptheria, Tetanus, & Wooping cough)		
Polio		
Rotavirus		
Pneumococcal (PCV)		
Chicken pox (varicella)		
Measles, mumps, & rubella (MMR)		
Hepatitis A		
Influenza (Flu)		
Others		

G. COVID-19 HEALTH DECLARATION RECORD (Please attach a copy of COVID-19 Vaccination record)

1. Has your child contracted COVID-19 virus?
   - ☐ YES
   - ☐ NO

If yes please provide necessary information below:

a. Date/s contracted the virus : _____

b. Undergo COVID-19 Confirmatory Test :
   - ☐ Yes
   - ☐ No

If yes please check COVID-19 Confirmatory Test
   - ☐ Swab test
   - ☐ Saliva
   - ☐ Others _____

c. COVID-19 Classification & Diagnosis:
   - ☐ Asymptomatic (no symptoms at all, but COVID positive)
   - ☐ Symptomatic (with symptoms and COVID positive)

d. Have been in a quarantine facility or home isolation?
   - ☐ Yes
   - ☐ No

If yes please state the location and date of Isolation/Quarantine _____

e. Total no. of days of Isolation
   - ☐ 10 days
   - ☐ 14 days
   - ☐ 21 days

2. Was your child already given COVID-19 vaccine?
   - ☐ Yes
   - ☐ No, Reason: _____

If yes how many doses? (This is a required information)
   - ☐ 1st dose Date given : _____
   - ☐ 2nd dose Date given : _____

3. Name/ Brand of Vaccine:
   - ☐ Sinovac
   - ☐ Astraseneca
   - ☐ Pfizer
   - ☐ Moderna
   - ☐ Others _____

4. Is your child already receive a booster dose? (SHS only)
   - ☐ Yes, Date : _____
   - ☐ No
   - ☐ 1st Booster dose
   - ☐ 2nd Booster dose
   - ☐ No, Reason : _____

5. Name/Type of Booster Vaccine :
   - ☐ Sinovac
   - ☐ Astraseneca
   - ☐ Pfizer
   - ☐ Moderna

Others _____

_____ Parent/Guardian Signature over Printed Name

_____ Date Submitted