DIVINE WORD COLLEGE OF LEGAZPI
Senior High School Department
HEALTH SERVICES UNIT

STUDENT'S MEDICAL RECORD

Grade Level: _____

Name: _____ Age: _____ Sex: _____

Home Address: _____

Temporary Address: _____

Father: _____ Contact: _____

Mother: _____ Contact: _____

Please tick box if you have/had any of the following illnesses:

( ) Polio ( ) Tetanus ( ) Chicken Pox

( ) Measles ( ) Mumps ( ) Pulmonary Tuberculosis

( ) Asthma ( ) Hepatitis ( ) Fainting Spells

( ) Seizure/Epilepsy ( ) Bleeding Tendencies ( ) Eye Disorder

( ) Heart Ailment (pls. specify): _____

( )Other Illness (pls. specify): _____

Do you have any allergy to:

1) Food: _____Yes _____No

Please specify: _____

2) Medicine: _____Yes _____No

Please specify: _____

Would you allow your child to be given medicine (as needed) while here in the school?

_____Yes _____No

Is your child taking any medications at present? If YES, please list the name of the medicine/s:

Person to be notified in case of emergency: _____

Contact: _____ Relationship: _____