HEALTH SERVICES UNIT – GS and JHS Department
DWCL North Campus
Washington Drive, Legazpi City, 4500 Philippines

STUDENT'S HEALTH PROFILE

PERSONAL INFORMATION

Grade Level: _____

Name: _____ Age: _____ Sex: _____

Home Address: _____

Present Address: _____

Father's Name: _____ Contact No: _____

Mother's Name: _____ Contact No: _____

Religion: _____ Nationality: _____

Primary Language Spoken (Bicol, Tagalog, English, etc.) _____

Student lives with: ( ) Both Parents; ( ) Mother; ( ) Father; ( ) Guardian

Guardian's Name (In case the student is living with guardian): _____

Guardian's relation to the student: _____ Contact No: _____

Alternate Person to Contact in case of Emergency: _____

Relationship to the student: _____ Contact No: _____

IMMUNIZATION

Please tick the box if your child/ward had completed the following Primary immunizations.

( ) BCG ( ) Hepa B

( ) DPT ( ) Measles

( ) OPV ( ) Others: _____

Does your child/ward have COVID-19 Vaccination? (If with First, Second or Booster dose, please attach a photocopy of Vaccination card)

( ) First Dose Only ( ) No

( ) Second Dose

( ) Booster Dose

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Medical History

Does your child have and/or history of the following conditions?

( ) Asthma
( ) Allergic Rhinitis
( ) Anxiety Disorder
( ) Bleeding/Clotting Disorder
( ) Chicken Pox
( ) Dermatitis/Skin Problem
( ) Diabetes Mellitus
( ) Dysmenorrhea/Menstrual Cramps
( ) Fainting Spells
( ) Frequent Headache
( ) G6PD
( ) Hearing Problem
( ) Hyperacidity/Gastritis
( ) Hypertension
( ) Hyperventilation
( ) Others: _____

Does your child have a Heart condition? (If Yes, please specify.)

_____

Does your child have an Eye condition? (If Yes, please specify.)

_____

Does your child have a history of serious illness and/or hospitalization? (Please specify and include dates.)

_____

Does your child have a history of surgeries and/or injuries? (Please specify and include dates.)

_____

Does your child receive any medication or medical treatment, either regularly or occasionally? (If Yes, please explain.)

_____

Does your child have any allergies to medication? (If Yes, please specify.)

_____

Does your child have any allergies to food? (If Yes, please specify.)

_____

Would you allow your child/ward to receive minor first aid (medication & treatment) given by the nurse in the school clinic?

_____

Do you have any other concerns related to your child's health? (If Yes, please explain.)

_____

_____

I hereby certify that all the information is true and correct.

_____

Signature of Parent/Guardian Over Printed Name

Note:
Kindly advise the adviser/ and or the School clinic staff if any change occurs in the medical or physical condition of the student at any time during the school year.

Your Success… Our Word!

(052) 480 2148 dwclinfo@dwc-legazpi.edu www.dwc.legazpi.edu