PUP-HIFS-6-MEDS-020
Rev.2
March 22, 2022

Republic of the Philippines
POLYTECHNIC UNIVERSITY OF THE PHILIPPINES
Office of the Vice President for Administration
MEDICAL SERVICES DEPARTMENT

2x2 or passport size current colored ID photo

HEALTH INFORMATION FORM FOR STUDENTS

PART I. STUDENT INFORMATION

Name: _____ ***PUP Student No.:*** _____
Home: Address: _____ ***School Year:*** _____
Age: _____ ***Sex:*** _____ ***Civil Status:*** _____ ***Course/ College:*** _____
Parent's Name/ Guardian/ Spouse: _____
Landline: _____ ***Cellphone:*** _____

PART II. MEDICAL HISTORY

1. ***Do you need medical attention or has known medical illness? ( ) No ( ) Yes***
   (Please check the following that apply as needed)

( ) Asthma	( ) Loss of Consciousness	( ) Eye Disease/ Defect	( ) Accident Injuries
( ) Diabetes	( ) Heart Disease	( ) Kidney Disease	( ) Tuberculosis / Primary Complex
( ) Convulsion/ Epilepsy	( ) Hyperventilation	( ) Hemophilia	
( ) Migraine	( ) High Blood Pressure		

2. ***Do you have disability? ( ) None ( ) Yes, What type of disability?*** _____
3. ***Additional Information for Students and Medical Conditions:***
   As a Parent/ Guardian, I would like to declare that my child has history of allergies to the following:
   Food: _____ No Known Allergies: _____
   Medicines: ☐ Aspirin ☐ Ibuprofen ☐ Amoxicillin
   ☐ Mefenamic Acid ☐ Penicillin ☐ Others: _____

PART III. PERSONAL SOCIAL HISTORY

Cigarette Smoking:	( ) Yes	( ) No
Alcohol Drinking	( ) Yes	( ) No

I hereby stated to the best of my knowledge, my answer to the above questions are completed and correct.

By affixing my signature (Parent/Guardian and Student), I agree to the Data Privacy Act of 2012 and its implementing rules and regulations and voluntarily giving my consent in the collection and processing of the student's name above its Personal Information in accordance with such as health assessment, treatment and/or research following research ethics guidelines for the improvements of healthcare services. This consent will remain in full force until I revoke it in writing.

_____	_____	_____
Signature of Parent/Guardian	**Signature of Student**	**Date**

For PUP Physician's Only
Please Check

Medical Clearance: ☐ ***Issued*** ☐ ***Pending*** ***Reason:*** _____

_____	_____
Date:	***Physician's name and signature***