Republic of the Philippines
POLYTECHNIC UNIVERSITY OF THE PHILIPPINES
Office of the Vice President for Administration
Medical Services Department

PUP-OMS-MEDS-040
Rev 0
July 17, 2024

Declaration of Medical Information and Data Subject Consent Form

I hereby certify that the medical health information given to the physician and nurses of Polytechnic University of the Philippines (PUP) during my on-site consultation for the issuance of medical clearance for off-campus activity/ies are true, correct and complete to the best of my knowledge. I have fully disclosed all the medical condition that may affect in the assessment to endorse my participation in the _____ activity/ties as a student of PUP.

I also understand that the PUP Medical Services and University will not be liable for any untoward incident that may arise due to my failure to disclose accurate information or intentionally providing false and deceptive information.

In compliance with the Data Privacy Act of 2012 and its implementing Rules and Regulations, I voluntarily consent to the collection, processing and storage of my personal and health information for the purpose/s of health assessment, treatment/ or research (following research ethics guidelines) for the improvement of healthcare services.

_____
Student's Signature Over Printed Name/ Date

Remarks:

_____
Guardian's Signature Over Printed Name/ Date

Both student and guardian will affix their signature if the student is aged below 18 years old.

PHYSICIANS NOTES

Republic of the Philippines
POLYTECHNIC UNIVERSITY OF THE PHILIPPINES
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MEDICAL SERVICES DEPARTMENT

HEALTH EXAMINATION RECORD

FACULTY, ADMINISTRATIVE EMPLOYEE AND STUDENT

Name:	Date:
Address:	College / Department
Contact No.:	Course/School Year:
Contact Person In Case of Emergency:	Contact No.:
Age: Sex: Civil Status:	
I. PAST MEDICAL HISTORY	***Chest X-Ray Result:*** ( ) Normal
Childhood Illness:	( ) With findings _____
( ) Asthma ( ) Chicken Pox	
( ) Heart Disease ( ) Measles	***Breast:*** ( ) Normal
( ) Seizure Disorder ( ) Hyperventilation	
( ) Others	***Heart:*** Murmur: ( ) Present ( ) Absent
Previous Hospitalization: ( ) No ( ) Yes	Rhythm ( ) Regular ( ) Irregular
Operation/Surgery: ( ) No ( ) Yes	
	Abdomen: ( ) Normal
Current Medications:	
Allergies: _____	***Genito-Urinary:*** 1st day of last Menstruation _____
II. FAMILY HISTORY	***Estremities:*** ( ) No Deformities
( ) Diabetes ( ) PTB	
( ) Hypertension ( ) Cancer	***Vertebral Column*** ( ) Normal
( ) Others	( ) With Deformity _____
III. PERSONAL HISTORY	***Skin:*** ( ) Pallor ( ) Rashes ( ) Lesions
Cigarette Smoking: ( ) No ( ) Yes	Scars: ( ) Absent ( ) Present
Alcohol Drinking: ( ) No ( ) Yes	
Traveled Abroad: ( ) No ( ) Yes	***WORKING IMPRESSION:***
IV. PHYSICAL EXAMINATION	***Fit:***
Vital Signs: ( ) Not in Distress ( ) In Distress	
Ht. _____ Wt. _____ Kg. BMI: _____	***For Work-Up:***
BP _____ HR _____ /min	
RR _____ /min Temp.	***Referred to:***
	( ) Cardio ( ) Pulmo
Head: ( ) Wound ( ) Mass ( ) Alopecia	( ) Derma ( ) Others:
	( ) ENT
Eyes: ( ) w/o Glasses ( ) w/ Glasses	( ) Optha
( ) Anicteric Sclera ( ) Pink Palpebral Conjunctiva	
	Follow up on:
Ears: ( ) No Gross Deformity ( ) No Discharge	***Physician's Signature:***
Throat: ( ) No TPC ( ) No Mass	
( ) No lymphadenopathy	***By affixing my signature, I am agreeing to the PUP Data Privacy Policy and giving my consent in the collection and processing of my Personal Information in accordance thereto.***
Chest/Lungs: ( ) Normal ( ) Wheeze ( ) Rales	