



Eden Street, Ma-a, Davao City
(082) 244-0587 / (082) 327-8550

Learner’s Medical History

Dear Parent/Guardian,

In order to provide the best education experience in Southpoint School, school personnel must understand your child’s health needs. This form requests information from you which will also be helpful to the health care provider when he or she completes the medical evaluation.

Learner’s Name (Last Name, First Name, Middle Name) Birthdate (mm/dd/yyyy) Age Year Level

Complete House Address Gender Nationality

Name of Parent/Guardian (Last Name, First Name, Middle Name) Occupation Mobile No.

Where do you usually take your child for medical care? Where do you usually take your child for dental care?

Name of Clinic/Hospital Name of Clinic/Hospital

Physician & Contact No. Dentist & Contact No.

To the best of your knowledge, has your child had any problem with the following?

	NO	YES	AGE	If YES, kindly explain your answer. You may also include any additional concerns here.
Seizure				
Chickenpox				
Dengue Fever				
Measles				
Mumps				
Primary Complex				
Tonsillitis				
Asthma or Breathing Problems				
Any injuries that prohibited participation in sports				
Any broken bones or dislocation				
Any muscle or joint injuries				
Any heart problems/blood pressure				
Any problems with vision				
Any dental concerns				
Any hospitalizations				
Any surgery				
Allergies (food, insect, drug, latex, etc.)				
Any daily medications				
Any special medications				
Any other health concerns				

Is there anything you want to discuss to the school nurse? Is yes, please explain.

Full Name of Parent/Guardian (include e-signature if available) Date