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

( ) Second Dose

( ) Booster Dose

( ) No

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!

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