DEPARTMENT OF EDUCATION
REGION V (Bicol)
SCHOOLS DIVISION OF LEGAZPI CITY
PAG-ASA NATIONAL HIGH SCHOOL
Rawis, Legazpi City

STUDENT MEDICAL FORM

This Medical Form must be on file at the School Health Clinic on the date the student enters school. The School Office must be notified of a guardianship anytime that parents leave without their children.

The information on this form will be treated as confidential and will only be shared with school personnel on a nedd-to-know basis.

FOR OFFICIAL USE

Year Level : _____ Section: _____
Age : _____

STUDENT AND FAMILY INFORMATION

Student's Name: _____ Age:_____
Last Name First Name Middle Name

Gender: ☐ Male ☐ Female Date of Birth: _____/_____/_____ Nationality:_____
MM DD YY

Student resides with: ☐ Both Parents ☐ Father ☐ Mother ☐ Guardian

Father/Guardian's Name _____ Age: ___ Nationality: _____
Home Address: _____
Contact No.:_____
Email Add: _____

Mother/Guardian's Name _____ Age: ___ Nationality: _____
Home Address: _____
Contact No.:_____
Email Add: _____

FOR EMERGENCY (If parents cannot be reached)

Primary Contact: _____ Phone #: _____
Relationship: _____
Secondary Contact: _____ Phone #: _____
Relationship: _____

MEDICAL INFORMATION AND HEALTH HISTORY

ALLERGIES (Please list any known allergies):

Medications:	Food:	Others:
1. _____	1. _____	1._____
2. _____	2. _____	2._____
3. _____	3. _____	3._____

Any history of severe allergic reaction or anaphylactic reaction? Yes ☐ No ☐
Asthma? Yes ☐ No ☐ Does the student carry an asthma inhaler? Yes ☐ No ☐
Does the student have any present illness? Yes ☐ No ☐

If yes, please describe:_____
_____
_____

HEALTH HISTORY: Please indicate if the student has had any of the following conditions. If the answer is yes to any, please give details below.

	No	Yes	Age		No	Yes	Age
Diabetes				Scoliosis			
Meningitis				Skin Disease			
Tuberculosis				Psoriasis			
Pneumonia				Vitiligo			
Fainting Spells				Atopic Dermatitis			
Heart Disorder				Impetigo			
Urinary Disorder				Other Illnesses/			
Epilepsy /Seizures				Conditions:			

Describe: _____
_____
_____

Any hospitalizations or serious injuries/illness?(Please give details): _____
_____
_____

Does the student wear eyeglasses or contact lenses? Yes ☐ No ☐
Eye or vision problems? Yes ☐ No ☐
Please describe:_____
_____

Hearing problems or ear infection? Yes ☐ No ☐
Please describe:_____
_____

IMMUNIZATION RECORD

	Date	Date	Date	Date	Date
DPT/DT					
Polio					
Measles					
Mumps					
Rubella					
Typhoid injection/oral every 3 years					
Tetanus booster (between ages 12-15)					
Hepatitis A					
Hepatitis B					
Varicella (Chicken Pox)					
Others:					

I verify that all information provided on this form is complete and correct.

I acknowledge that it is my responsibility to inform the MG International School authorities of any changes in the student's health, physical condition and medical needs.

_____ Date: _____

Student's Signature over Printed Name