COLLEGE OF THE HOLY SPIRIT MANILA
WELLNESS CENTER

STUDENT'S HEALTH RECORD

PART I SCHOOL YEAR: _______________

GENERAL DATA (To be filled up by Parent or Guardian) GRADE/YEAR LEVEL: _________________

FAMILY NAME:		GIVEN NAME:	MIDDLE NAME:
SEX:		BIRTH DATE:	BIRTHPLACE:
RELIGION:			NATIONALITY:
HOME ADDRESS:			CONTACT NUMBER:
MOTHER'S NAME:		OCCUPATION:	CONTACT NUMBER:
FATHER'S NAME:		OCCUPATION:	CONTACT NUMBER:
GUARDIAN'S NAME:		OCCUPATION:	CONTACT NUMBER:
NUMBER OF SIBLINGS:			BIRTH ORDER

FAMILY HISTORY							
DISEASE	NO	YES	WHO	DISEASE	NO	YES	WHO
CANCER				TUBERCULOSIS			
HEART PROBLEM				ASTHMA			
HYPERTENSION				TENDENCY TO BLEED			
DIABETES				MENTAL TROUBLE			

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PAST MEDICAL HISTORY (Previous disease/illness)

DISEASE/ILLNESS	TREATMENT/HOSPITALIZATION	DATE/YEAR	

OTHER INFORMATION

ANY SPECIAL MEDICATION?	ALLERGY TO MEDICINES? SPECIFY.
REQUIRES SPECIAL CARE:	OTHERS:

IMMUNIZATION RECORD

IMMUNIZATION	DATE	IMMUNIZATION	DATE
BCG		ANTI HEPATITIS B I	
DPT/OPV I		ANTI HEPATITIS B II	
DPT/OPV II		ANTI HEPATITIS B III	
DPT/OPV II		MMR	
DPT/OPV BOOSTER I		ANTI CHICKEN POX	
DPT/OPV BOOSTER II		ANTI HEPATITIS A I	
HiB I		ANTI HEPATITIS A II	
HiB II		ANTI HEPATITIS A III	
HiB III		ANTI TYPHOID FEVER	
ANTI MEASLES		OTHERS	

_____________________ DATE

_________________________________ PARENT'S/GUARDIAN'S SIGNATURE OVER PRINTED NAME

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PART II

PHYSICAL EXAMINATION (To be filled up by Family Physician)

Heart Rate ______ Respiratory Rate _______ Temperature _______

Weight ______ Height _______ Blood Pressure ______

Eyes With Glasses _______ Without Glasses _____

Ears Right _____________ Left _______________

Choose N if Normal and A if any abnormality is found

	N	A	ABNORMALITY		N	A	ABNORMALITY
SKIN				LUNGS			
NOSE				HEART			
MOUTH				ABDOMEN			
PHARYNX				RECTUM			
TONSILS				GENITALIA			
GUMS				SPINE			
LYMPH NODES				ARMS			
NECK				LEGS			
CHEST				FEET			

FINDINGS: ____

RECOMMENDATIONS:

____

____ ____________________ _________________________
NAME OF PHYSICIAN & SIGNATURE LICENSE NUMBER DATE