STUDENT HEALTH RECORD

Data Privacy Clause: By completing this form, I hereby agree that Miriam College Alviera may collect, use, disclose and process the personal data of the applicant for the purpose/s of reference for health-related concerns of the student while enrolled in Miriam College. Requests for inspection. Amendment or restriction of records must be in writing and addressed to Miriam College Alviera and must specify the reasons for the request. MC reserves the right to respond appropriately according to law.

NAME:

LAST   FIRST   MIDDLE   NICKNAME

ADDRESS:	
TEL. NO.:	
BIRTHDAY:	**SEX:**

FATHER'S NAME:	**MOTHER'S NAME:**
OCCUPATION:	**OCCUPATION:**
BUSINESS ADDRESS:	**BUSINESS ADDRESS:**
TEL. NO(S).:	**TEL. NO(S).:**
MOBILE NO.:	**MOBILE NO.:**

STUDENT FREQUENTLY HAD: (Please check)

- ☐ Abdominal pain
- ☐ Backache
- ☐ Chest pains
- ☐ Colds
- ☐ Cough
- ☐ Dizziness
- ☐ Fever
- ☐ Headache
- ☐ Easy fatigability
- ☐ Nose Bleeding
- ☐ Sore throat
- ☐ Others (specify):

PAST DISEASE: (Please check)

- ☐ Allergy
- ☐ Measles
- ☐ Primary complex
- ☐ Worms
- ☐ Asthma
- ☐ German Measles
- ☐ Typhoid
- ☐ Injuries
- ☐ Convulsions
- ☐ Mumps
- ☐ Tonsillitis
- ☐ Operation and/or Hospitalization (specify diagnosis):
- ☐ Chickenpox
- ☐ Whooping cough
- ☐ Bleeding Tendencies
- ☐ Diphtheria
- ☐ Urinary trouble
- ☐ Joint swelling
- ☐ Hepatitis
- ☐ Rheumatic fever
- ☐ Heart trouble

FAMILY DISEASE: (Please check)

- ☐ Cancer
- ☐ Heart disease
- ☐ Peptic ulcer
- ☐ Diabetes
- ☐ High blood pressure
- ☐ Tuberculosis
- ☐ Epilepsy
- ☐ Nervous breakdown
- ☐ Others (specify):

DRUG PREPARATION GIVEN TO CHILD IN CASE OF:

Fever:	Eye Problem:
Abdominal Pain:	Cough & Colds:
Headache:	Dizziness:
Others:	

We acknowledge the protocols of the school in communicating with parents, administering first aid, addressing emergency treatment, transporting to the nearest hospital that can provide the necessary medical management, and acquiring medical clearance when returning back to school after an injury or communicable disease.

IMMUNIZATION:

VACCINE	DATE(S) GIVEN
BCG	
DPT 1	
2	
3	
BOOSTER 1	
2	
POLIOMYELITIS/OPV 1	
2	
3	
BOOSTER 1	
2	
HIB 1	
2	
3	
4	
MEASLES	
CHICKEN POX	
OTHERS:	

VACCINE	DATE(S) GIVEN
MMR 1	
2	
TYPHOID 1	
2	
3	
HEPATITIS A 1	
2	
3	
HEPATITIS B 1	
2	
3	
4	

Attach a recent 2 x 2 colored photo

PLEASE CHECK AND NOTE IF THE CHILD:

- ☐ has any special medication: specify:
- ☐ requires special care: specify the nature:
- ☐ Has undergone or is currently undergoing any physical, behavioral, psychological, psychiatric, or cognitive interventions? specify the nature:
- ☐ is allergic to any drug preparation: specify:

IN CASE OF EMERGENCY (ACCIDENT OR ILLNESS) AND PARENTS CANNOT BE REACHED BY PHONE, ALTERNATE PERSONS TO BE NOTIFIED ARE:

1.	TEL. NO.:
2.	TEL. NO.:

DOCTOR TO BE NOTIFIED:	**TEL. NO.:**

CERTIFIED CORRECT:

SIGNATURE OF OVER PRINTED NAME OF PARENT/GUARDIAN AND DATE: