LA SALLE GREEN HILLS P.O. BOX 560 GREENHILS Mandaluyong City Philippines 721- 2000
HEALTH SERVICES
Tel. Nos. 726-58-45

STUDENT'S MEDICAL EXAMINATION RECORD

Name _____
(LAST NAME) (FIRST NAME) (MIDDLE NAME)

Grade/Year _____ Section _____

Home Address _____

Date of Birth _____ Place of Birth _____

Father's Name _____ Mother's Name _____

Res. Tel. Nos. _____ Res. Tel. Nos. _____

Mobile numbers _____ Mobile numbers _____

- ***In case of emergency (accident or illness) and parents cannot be reached by phone, alternate person(s) to be notified _____***
  Telephone number(s) _____ Mobile number(s) _____
  Presence of other members of the family in the school:
  Name _____ Department/ Grade / Year_____

To be filled out by Family Physician

PHYSICAL EXAMINATION

Vital Signs: PR _____ RR _____ HR _____ Temp. _____ BP _____
Ht. _____ and Wt. _____

General Survey:
Development ( ) Well ( ) Fair ( ) Poor
Nutrition ( ) Good ( ) Fair ( ) Poor

HEENT _____
Vision/ Hearing _____
Teeth and Gums _____
Chest and Breast _____
Lungs _____
Heart _____
Abdomen _____
Rectum and Anus _____
Genitals _____
Extremities _____
Skin and Glands _____
Others _____

PLS. SEE BACK PAGE

Please put an X on the appropriate box.

☐ **Physically fit to enroll and may participate in Physical Education including strenuous activities/ swimming/outdoor activities with sun exposure**

☐ **Physically fit to enroll and MAY participate in Physical Education EXCEPT _____**

☐ **Physically fit to enroll BUT NOT to participate in Physical Education**

Remarks _____
_____

***FOR VARSITY PLAYERS:**

☐ **PHYSICALLY FIT, DURING THE TIME OF EXAMINATION, TO JOIN THE VARSITY TEAM/ EXTRA- CURRICULAR ACTIVITIES REQUIRING PHYSICAL TRAINING.**

Date Examined _____ By: _____
Signature of Physician over printed name
License no. _____

To be filled out by Parents/ Guardian

PAST PERSONAL MEDICAL HISTORY RECORD

BLOOD TYPE: _____ **ALLERGIES**: _____

Does the student have any present or past experience of the following?

	YES	NO		YES	NO
Asthma			Stomach pain / Ulcer		
Heart Diseases/ Hypertension			Hernia (luslos)		
Diabetes			Hemorrhoids (almoranas)		
Tuberculosis/other Lung Diseases			Bleeding tendencies		
Kidney Diseases			Liver Diseases		
Allergy (food, drugs, etc.)			Typhoid (tipus)		
Frequent Headaches			Injuries/ Fractures		
Epilepsy / Convulsion			Chicken pox/Measles/mumps		
Behavioral Disorders			Hospitalizations/Surgeries		
Congenital Disease			Others		

- If your answer is "YES," please give relevant or important details especially on date, duration, frequency and outcome of the disease your son has suffered from:
  _____

- **Vaccination:** Give the last date your son has received any of the following. Only NEW students or those who have not yet previously accomplished this vaccine record are required to fill it up.

DPT _____ Typhoid Vaccine_____
BCG _____ OPV _____
Measles _____ Chicken Pox Vaccine _____
Hepatitis A _____ Hepatitis B _____
Influenza (HIB) _____ Flu_____
MMR _____ Others/ Boosters_____

- **All students have to present their completely accomplished and duly signed Medical form and submit together with the Admit pass to the adviser during first day of classes.**

- **Should there be ANY SPECIAL MEDICAL CONDITIONS/RESTRICTIONS IN PHYSICAL ACTIVITIES, please advise the Clinic and Principal in writing.**

_____ _____
Student's name / Grade & section ***Signature of Parent/Guardian over Printed Name***