Department of Science and Technology
PHILIPPINE SCIENCE HIGH SCHOOL - BICOL REGION CAMPUS
Tagongtong, Goa Camarines Sur
Telefax (054) 453-2048
www.pshs-brc.edu.ph

To Parent or Guardian:

In order to provide the best educational experience, school personnel must understand your child's health needs. This form request information from you (Part I) which will also be helpful to the health care provider when he or she completes the medical evaluation (Part II)

STUDENT NAME *(Last, First, Middle)*	Age	☐ Male ☐ Female	Birth Date (Month / Day / Year)
ADDRESS *(Street / Barangay, Municipal/City, Province, Zip Code)*			
Home Phone :	Father's Name :		Contact No.
Cell Phone :	Mother's Name :		Contact No.
Guardian (If any)*:	Address:		Contact No.
Preferred Hospital: (Name / Address)	Pediatrician / Family Doctor:	Are you a member of Philhealth?* ___Yes ___No If yes, Philhealth ID no.	

**if applicable*

PART I – TO BE COMPLETED BY PARENT/GUARDIAN.

Please answer these health questions about your child before the physical examination
Please circle Y if "yes" or N if "No". Explain all "yes" answers in the space provided below

Health History			(Explain if your Answer is Yes	Health History			Explain if your Answer is Yes
Any health concerns	Y	N		Hospitalization or emergency Room visit	Y	N	
Allergies to food or bee sting	Y	N		Problems running	Y	N	
Allergies to Medication	Y	N		Excessive weight gain/loss	Y	N	
Any other allergies	Y	N		Dental braces, caps, or bridges	Y	N	
Any daily medications	Y	N		Concussion	Y	N	
Any problems with medication	Y	N		Fainting or blacking out	Y	N	
Uses contacts or glasses	Y	N		Chest pain	Y	N	
Any problems in hearing	Y	N		Heart problems	Y	N	
Any problems with speech	Y	N		High Blood pressure	Y	N	
Any broken bones or dislocation	Y	N		Bleeding more than expected	Y	N	
Any muscle or joint injuries	Y	N		Problems breathing or coughing	Y	N	
Any neck or back injuries	Y	N		Any smoking	Y	N	
Asthma treatment (past 3 years)	Y	N		Diabetes	Y	N	
Seizure Treatment (past 2 years)	Y	N		ADHD / ADD	Y	N	

Please list any **Medications** your child will need to take in school including Vitamins: _____ None

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Is there anything you want to discuss with the school nurse/doctor? ___ Yes ____ No
If yes, Explain
_____

I give permission for release and exchange of information on this form between the school nurse and health care provider for confidential use in meeting my child's health and educational needs in school.	_____ *Signature over printed name of Parent/Guardian*	_____ *Date*

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PART II – MEDICAL EVALUATION

Health Care Provider must complete and sign the medical evaluation and physical examination

☐ I have reviewed the health history information provided in Part I of this form

Height	in.
Weight	lbs.
BMI	
Pulse	bmp
Blood Pressure	

	Normal	Describe Abnormal
Neurologic		
HEENT		
Lymphatic		
Heart		
Lungs		
Abdomen		
Genitalia / hernia		
Skin		

	Normal	Describe Abnormal
Neck		
Shoulder		
Arms/ hands		
Hips		
Knees		
Feet / ankles		
Postural: ☐ No spinal Abnormality ☐ Spine Abnormality __Mild __Moderate __Marked		

LABORATORY	RESULT
CBC	
Urinalysis	
Fecalysis	
Chest Xray	
ECG	

SCREENING

Vision Screening

Type	*Right eye*	*Left eye*
With glasses	20/	20/
Without glasses	20/	20/

Referral made: ☐

Auditory Screening

Type: Right Ear ☐ Pass ☐ Fail; Left Ear ☐ Pass ☐ Fail

Referral made: ☐

TB: High-risk group? ☐ No ☐ Yes PPD date read: _____ Result _____ Treatment (if any) _____

IMMUNIZATIONS

☐ Up to date or Catch up Schedule: MUST HAVE IMMUNIZATION RECORD ATTACHED

Name of Disease	CHRONIC DISEASE ASSESSMENT						
Asthma	☐ NO	☐ YES	☐ Intermittent	☐ Mild Persistent	☐ Moderate Persistent	☐ Severe Persistent	☐ Exercise Induced
Allergies	☐ NO	☐ YES	☐ Food	☐ Insect	☐ Latex	☐ Other/s:	
Diabetes	☐ NO	☐ YES	☐ Type I	☐ Type II	Other Chronic Disease:		
Seizures	☐ NO	☐ YES	Type:				

☐ This Student has developmental, emotional, behavioral, or psychiatric condition that may affect his or her educational experience.
Explain: _____
Daily Medication (Specify): _____

This student may: ☐ **Participate fully in the *school program***
☐ **Participate in the school program with the following restriction/adaptation:** _____

This student may: ☐ **Participate fully in *athletic activities and competitive sports***
☐ **Participate in athletic activities and competitive sports with following restriction/adaptation** _____

☐ YES ☐ NOT **PHYSICALLY FIT**

Based on this comprehensive health history and physical examination, this student has maintained his/her level of wellness.

_____, MD
Signature over Printed name of Health Care Provider
License No.
Date:

Clinic Address:
Clinic Phone No.