



ATENEO DE NAGA UNIVERSITY

JUNIOR HIGH SCHOOL DEPARTMENT

Km 7 Phelan Drive, Pacol, Naga City

2X2 photo with nametag

STUDENT HEALTH RECORD

This portion is to be filled up by parents(s) / guardian

GENERAL DATA

Family Name:	Age:	Nationality:
Given Name:	M.I.	Birthdate:
Religion:	Birthplace:	
Home Address:		
Mother's Name:	Age:	Occupation:
Tel No. Office:	Tel.No.(s)	Mobile No:
Father's Name:	Age:	Occupation:
Tel No. Office:	Tel.No.(s)	Mobile No:
Guardian's Name:	Age:	Occupation:
Tel No. Office:	Tel.No.(s)	Mobile No:
In case of emergency, notify (in the absence of parent(s) / guardian.		

FAMILY HISTORY

DISEASE	YES	NO	RELATION	DISEASE	YES	NO	RELATION
CANCER				ASTHMA			
HEART PROBLEM				BLEEDING PROBLEM			
HYPERTENSION				MENTAL TROUBLE			
DIABETES				LEARNING DISABILITY			
TUBERCULOSIS				OTHERS			
CONVULSION							

PAST MEDICAL HISTORY

DISEASE	YES	NO	DISEASE	YES	NO	DISEASE	YES	NO
ALLERGY			CHICKEN POX			HEART PROBLEM		
ASTHMA			DENGUE FEVER			KIDNEY		
ANEMIA			TYPHOID FEVER			CONVULSION		
BEHAVIORAL PROBLEM			MEASLES			EPILEPSY		
HEARING PROBLEM			MUMPS			DIABETES		
SPEECH PROBLEM			PNEUMONIA			FAINTING SPELLS		
VISUAL PROBLEM			PRIMARY COMPLEX			FRACTURES		
RECURRENT INDIGESTION			EAR DISCHARGE			HOSPITALIZATION		
			TONSILITIS			OPERATION		

If answer is YES, please give relevant details:

OTHER INFORMATION

Any Special MEDICATION	ALLERGY to MEDICINES?
REQUIRES special care?	Others:

Accomplished by:

Signature over PRINTED NAME

Relation to Student

DATE

This portion is to be filled up by the family Physician / Pediatrician

IMMUNIZATION

VACCINE	DATE(S) GIVEN	VACCINE	DATE(S) GIVEN
BCG		MMR 1	
DPT 1		2	
2		3	
3		TYPHOID 1	
BOOSTER 1		2	
2		3	
OPV 1		HEPATITIS A 1	
2		2	
3		3	
BOOSTER 1		HEPATITIS B 1	
2		2	
HIB 1		3	
2		CHICKEN POX	
3		OTHERS:	
4			
MEASLES			

Preferred hospital in case of emergency: _____

PHYSICAL EXAMINATION (For the Physician)

	Grade 7	Grade 8	Grade 9	Grade 10		Grade 7	Grade 8	Grade 9	Grade 10
Date of Examination					Date of Examination				
Height					Abdomen				
Weight					Spleen				
Pulse Rate					Liver				
BP					Spine				
Nutrition					Extremities				
Posture					Speech				
Lymph Nodes					Neurological				
Skin					Menarche				
Visual Acuity					Deformities				
Ears / Nose					Others specify				
Mouth / Throat									
Lungs									
Heart									
Breast									

ASSESSMENT:

Essentially Normal Physical Examination Findings:

With limitation of Activities:

Requires special Attention:

Examining Physician: _____

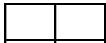
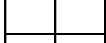




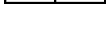

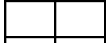
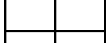
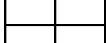
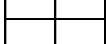

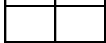

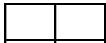
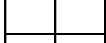




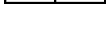

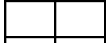
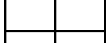
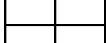
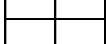

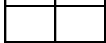

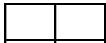
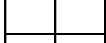




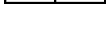

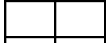
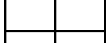
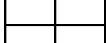
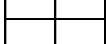

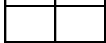

License No. _____

Signature: _____

Date: _____

NAME:		
(Last Name)	(First Name)	(M.I.)
HOME ADDRESS:		
SCHOOL:		YR LEVEL /SECTION:
AGE:		GENDER:
COMPLAINTS:		

STANDARD VISION SCREENING FORM

FAR ACUITY	NEAR ACUITY																																																		
<table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: right;">2</td> <td style="width: 85%;"></td> <td style="width: 10%; text-align: right;">20 / 100</td> </tr> <tr> <td>3</td> <td></td> <td style="text-align: right;">20 / 70</td> </tr> <tr> <td>4</td> <td></td> <td style="text-align: right;">20 / 50</td> </tr> <tr> <td>5</td> <td></td> <td style="text-align: right;">20 / 40</td> </tr> <tr> <td>6</td> <td></td> <td style="text-align: right;">20 / 30</td> </tr> <tr> <td>7</td> <td></td> <td style="text-align: right;">20 / 25</td> </tr> <tr> <td>8</td> <td></td> <td style="text-align: right;">20/20</td> </tr> </table> <p style="text-align: center;">VA at FAR RIGHT EYE</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div> <p style="text-align: center;">LEFT EYE</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: right;">1</td> <td style="width: 85%;"></td> <td style="width: 10%; text-align: right;">20 / 200</td> </tr> <tr> <td>2</td> <td></td> <td style="text-align: right;">20 / 100</td> </tr> <tr> <td>3</td> <td></td> <td style="text-align: right;">20 / 70</td> </tr> <tr> <td>4</td> <td></td> <td style="text-align: right;">20 / 50</td> </tr> <tr> <td>5</td> <td></td> <td style="text-align: right;">20 / 40</td> </tr> <tr> <td>6</td> <td></td> <td style="text-align: right;">20 / 30</td> </tr> <tr> <td>7</td> <td></td> <td style="text-align: right;">20 / 25</td> </tr> <tr> <td>8</td> <td></td> <td style="text-align: right;">20/20</td> </tr> </table> <p style="text-align: center;">VA at FAR LEFT EYE</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>	2		20 / 100	3		20 / 70	4		20 / 50	5		20 / 40	6		20 / 30	7		20 / 25	8		20/20	1		20 / 200	2		20 / 100	3		20 / 70	4		20 / 50	5		20 / 40	6		20 / 30	7		20 / 25	8		20/20	<p style="text-align: center;">RIGHT EYE</p> <div style="border: 1px solid black; height: 50px; width: 100%;"></div> <p style="text-align: center;">LEFT EYE</p> <div style="border: 1px solid black; height: 50px; width: 100%;"></div> <p>PD _____</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td rowspan="2" style="text-align: center; vertical-align: middle; font-size: 24px;">Rx</td> <td style="text-align: center;">OD</td> <td style="width: 100px;"></td> </tr> <tr> <td style="text-align: center;">OS</td> <td></td> </tr> </table> <p>External Examination: _____</p> <p>Ophthalmoscopy: _____</p> <p>Evaluation: _____</p> <p>Management: _____</p> <p>Screened by: _____</p> <p>Date of Screening: _____</p>	Rx	OD		OS	
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ORAL HEALTH EXAMINATION RECORD

MEDICAL HISTORY:

HYPERTENSION	EPILEPSY	ALLERGIES
DIABETES	BLEEDING DISORDER	OTHERS:
CARDIO VASCULAR DIS.	ASTMA	(please specify)

