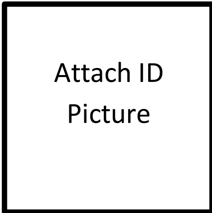
LORENZO RUIZ DE MANILA SCHOOL
Vista Verde Executive Village, Cainta, Rizal
Trunk lines: 682-18-41/6821842
Website: www.lorenzoruiz.edu.ph



STUDENT'S MEDICAL HISTORY FORM

I. PERSONAL DATA

Name: ____ Age: _________ Gender:______
Grade Level: ___________________________ Section: _____________ Tel. No. _______________
Home Address: ____
Date of Birth: ______________________________________ Place of Birth : _______________
Father's Name: _____________________________________ Occupation: _________________
Business Address: ___________________________________ Tel. No: ___________________
Mother's Name: _____________________________________ Occupation: ________________
Business Address: ___________________________________ Tel. No.: __________________

- Person to be notified in case of emergency and parents cannot be reached by phone:
  Name:____
  Relationship to the student: ____
  Tel. No.____
- Brother/s or sister/s enrolled in Lorenzo Ruiz de Manila School:
  Name :_____________________________ Grade/ Year : _________ Section: ____________
  Name :_____________________________ Grade/ Year : _________ Section: ____________
  Name :_____________________________ Grade/ Year : _________ Section: ____________

II. MEDICAL HISTORY RECORD

- Has the child suffered from any of the following? (Use "x" to indicate answer)

	YES	NO		YES	NO
1. Malaria	____	____	13. Diabetes	____	____
2. Pulmonary Tuberculosis	____	____	14. Kidney Diseases	____	____
3. Typhoid	____	____	15. Liver Diseases	____	____
4. Colds	____	____	16. Gastrointestinal Diseases	____	____
5. Cholera/ Dysentery/ Diarrhea	____	____	17. Epilepsy/ Convulsion	____	____
6. Bronchial Asthma	____	____	18. Heart Disease	____	____
7. Influenza	____	____	19. Hernia	____	____
8. Chicken Pox	____	____	20. Hemorrhoids	____	____
9. Measles	____	____	21. Anemia/ Blood Dyspraxia	____	____
10. German measles	____	____	22. EENT Diseasses	____	____
11. Mumps	____	____	23. Injuries/ Deformities	____	____
12. Skin Diseases/ Allergies	____	____	24. Operation/ Others	____	____

- If your answer is "YES", please give the relevant or important details especially on date, duration, frequency, outcome of the disease the child had or has:
  ____
  ____
  ____
- When was the child's last X-ray?_________________________ Result: ______________________
- Has the child ever been hospitalized? ( ) YES ( ) NO
  If so, state where and for what reason:
  ____
  ____

III. IMMUNIZATION PERIOD:

VACCINATION: Date Given:

	1	2	3	BOOSTERS		1	2	3	BOOSTERS
BCG	____	____	____	_________	Measles	____	____	____	_________
DPT	____	____	____	_________	MMR	____	____	____	_________
Polio	____	____	____	_________	Typhoid V	____	____	____	_________
Hepa B	____	____	____	_________	Chicken Pox	____	____	____	_________

Accomplished by:

____
Printed name/Relation to the student