



STUDENT HEALTH RECORD

Dear Parents/Guardians,

Attached is the copy of the complete medical form. We would like to ask you to furnish us with data concerning your child/ward’s past illnesses, immunizations, surgeries if any, and other health information that may be relevant to your child/ward’s health.

We assure you that all information obtained will be treated with utmost confidentiality.

Thank you for your cooperation.

Sincerely,

SUJHS School Nurses

DEMOGRAPHIC DATA

Name: _____ Current Grade Level: _____
 Last First Middle
Date of Birth: _____ Place of Birth: _____
Gender: _____ Religion: _____ Nationality: _____
Address: _____ Home Phone No.: _____
Name of Parents:
 Father’s Name: _____ Cellphone No.: _____ Office No.: _____
 Mother’s Name: _____ Cellphone No.: _____ Office No.: _____

Person to be Notified in case of Emergency:
 Name: _____ Contact No.: _____

List two neighbors or nearby relatives who will assure temporary care of your child/ward if you be reached:
 Name: _____ Contact No.: _____
 Name: _____ Contact No.: _____

MEDICAL HISTORY

1. **List any health conditions** such as *asthma, eye or ear problems, heart diseases, diabetes, epilepsy, or any other conditions* of which the school should be aware of. _____

Note: If you have SPECIFIC EMERGENCY PLANS for your child/ward s specific health condition, please do inform the school.

2. **ALLERGIES:** Kindly list your child/ward’s allergies. Include foods, drugs, plants, animals.

3. Is your child/ward receiving current or



IMMUNIZATION RECORD

1. Kindly check the appropriate boxes for the immunizations your child/ward has received.

VACCINE	YES	NO	VACCINE	YES	NO
BCG			Chicken Pox		
OPV			Flu		
DPT			Hepatitis A		
Measles			Hepatitis B		
MMR			Pneumococcal		
COVID			Others (Pls specify)		
1 st Dose					
2 nd Dose					
Booster					