SCHOOL OF THE HOLY SPIRIT OF QUEZON CITY
BF Homes, Quezon City

* *MEDICAL RECORD* *

NAME (PRINT) _____ _____ _____
(Surname) (Given Name) (M.I.) (Level) (School year)

DATE OF BIRTH _____ **PLACE OF BIRTH** _____

PARENTS/GUARDIAN: _____ _____
(Father) (Mother)

Occupation _____ _____
Name of Company _____ _____
Office Address _____ _____
Office Tel./Mobile No. _____ _____

HOME ADDRESS _____ Home Phone/Mobile#_____

Person/s to be notified if parents cannot be reached in case of emergency: _____

_____
(Address) (Tel./Mobile No.)

I. PAST MEDICAL HISTORY: (Please refer to the following list of medical conditions that your child previously experienced. Kindly indicate the date of disease's onset.)

Date		Date		Date		Date	
_____	Allergy to drug/food (specify)	_____	Ear Infections	_____	Hernia	____	Whooping Cough
_____	Asthma			_____	Kidney Disease/UTI	____	COVID-19
_____	Bleeding/hematologic conditions (e.g. epistaxis, G6PD, anemia)	_____	Fracture/Surgeries	_____	Measles		Other _____
_____	Chicken Pox	_____	Gastritis/Hyperacidity	_____	Meningitis		
_____	Congenital Anomalies	_____	German Measles	_____	Mumps		
_____	Dengue	_____	Heart Disease (pls. specify.)	_____	Tonsilitis		
_____	Diabetes	_____	Hepatitis A/B	_____	Typhoid Fever		

Has history of past operation/s or serious physical injury? If yes, what and when?

_____

II. PHYSICAL AILMENT AND OTHER HEALTH CONCERNS/CONDITIONS:

Is there any specific ailment or any health condition/s (physical, mental, or psychological) that your child currently suffers from? Please list medication/s that your child is currently taking/maintaining.

_____

If yes, he/she is required to bring along his/her medicines. This will be properly labeled and kept in school clinic for his/her own use if needed.

**Pls. also submit medical clearance from attending pediatrician/psychiatrist or medical doctor signifying that s/he is fit to attend regular school.*

III. FAMILY HISTORY (Please check.)

____ Heart Disease _____ Asthma/TB ____ Psychiatric History ____ Diabetes

____ Epilepsy/convulsion ____ Kidney disease ____ Hypertension ____ Malignancy

IV. MENSTRUAL HISTORY

Menarche (date of onset of menstruation) _____

Duration _____ Interval_____

Dysmenorrhea and associated symptoms _____ If yes, medicine given _____

WILL YOU ALLOW SHSQC TO BRING YOUR CHILD TO THE NEAREST HOSPITAL IN CASE OF EMERGENCY?

_____ Yes _____ No

VACCINES FROM NEWBORN TO 8 YEARS OLD, ADOLESCENTS FROM 9-18 YEARS OLD AND 364 DAYS.

VACCINE	DOSE	TYPE (Brand of Vaccine e.g. Prevenar 15 or Pneumovax)	DATE	REACTION (+/-)
BCG	-			
HEPATITIS B	1			
	2			
	3			
	4			
DPT	1			
	2			
boosters	3			
	1			
	2			
OPV/IPV	1			
	2			
boosters	3			
	1			
	2			
H. INFLUENZAE B	1			
	2			
	3			
	4			
PNEUMOCOCCAL CONJUGATE (PCV)	1			
	2			
	3			
	4			
PNEUMOCOCCAL POLYSACCHARIDE (PPV)	1			
ROTAVIRUS	1			
	2			
	3			
INFLUENZA	1			
	2			
	3			
	4			
	5			
MEASLES	1			
MMR	1			
	2			
VARICELLA	1			
	2			
HEPATITIS A	1			
	2			
JAPANESE ENCEPHALITIS	1			
	2			
MENINGOCOCCAL	1			
TYPHOID	1			
	2			
HPV	1			
	2			
	3			
COVID-19	1			
	2			
OTHERS				

**If baby book is lost, please accomplish the above updated vaccine table from attending physician.*
**If baby book is available, please photocopy and attach here the said copy.*

Permission is granted to the School Medical Staff to administer emergency care and treatment as medical needs arise.

_____
Date

_____
Signature of Parent/Guardian over Printed Name