



Student Health Card and Physical Examination Record

This Health Card and the Physical Examination Record must be on file at the School Health Clinic on the date the student enters school. The child's School Office must be notified of a guardianship anytime that parents leave Manila without their children.

Photo  
3 x 4 cm

**FOR OFFICE USE:**  
SCHOOL YEAR/ GRADE/ AGE

*The information on this form will be treated as confidential and will only be shared with school personnel on a need-to-know basis.*

STUDENT ID# \_\_\_\_\_

**IMPORTANT: PARENTS MUST FILL OUT THE INFORMATION REQUESTED BELOW (IN PRINT) AND COMPLETE PAGES 2-3 OF THIS FORM. PAGE 4 MUST BE COMPLETED BY A LICENSED PHYSICIAN NO MORE THAN 12 MONTHS BEFORE EXPECTED START DATE.**

**Student and Family Information**

Student's Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_  
*Family Name First Name Middle Name*

Sex *M F* Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Nationality: \_\_\_\_\_  
*at Birth: mm dd yyyy*

Student resides with:  Both Parents/ Guardians  Parent/ Guardian One  Parent/ Guardian Two

**PARENT/ LEGAL GUARDIAN ONE:**  
Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_  
Mobile Phone #: \_\_\_\_\_  
Direct Office Line #: \_\_\_\_\_  
Office Phone #: \_\_\_\_\_  
Company Name: \_\_\_\_\_  
Languages Spoken: \_\_\_\_\_

**PARENT/ LEGAL GUARDIAN TWO:**  
Name: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Home Phone #: \_\_\_\_\_  
Mobile Phone #: \_\_\_\_\_  
Direct Office Line #: \_\_\_\_\_  
Office Phone #: \_\_\_\_\_  
Company Name: \_\_\_\_\_  
Languages Spoken: \_\_\_\_\_

**For Emergency (If Parents Cannot Be Reached)\***

*\*Domestic helpers do not qualify as guardians, regardless of the student's age.*

Primary Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_ Mobile #: \_\_\_\_\_  
Secondary Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_ Mobile #: \_\_\_\_\_  
Local Doctor or Health Care Provider: \_\_\_\_\_ Phone #: \_\_\_\_\_

**NOTE: Please notify the Admissions Office of any changes in phone numbers or contact persons.**

# MEDICAL INFORMATION and HEALTH HISTORY

**Student's Name:** \_\_\_\_\_  
Family Name
First Name
Middle Name

1) **Allergies?**  No  Yes **What is the allergy to? (foods, drugs, etc.)** \_\_\_\_\_

**Reaction:** \_\_\_\_\_

*If yes, is there history of severe allergy or anaphylactic reaction?*  No  Yes

*Does the student carry an AAI (adrenalin auto-injector, e.g. EpiPen)?*  No  Yes

**Please obtain the Anaphylaxis Management Form from the Health Clinic/ ISM website and see the Clinic Administrator.**

2) **History of serious respiratory reaction to a food, bee sting or a drug?** \_\_\_\_\_

3) **Asthma?**  No  Yes **Does the student carry an asthma inhaler?**  No  Yes

4) **Is the student on regular medication:**  No  Yes

**Name of the medication/s and frequency:** \_\_\_\_\_

*Does the student need to take any medication/s during school hours?*  No  Yes

*(If so, a letter from the Medical Doctor must be kept on file in the Health Clinic and the medication/s kept in the Clinic to be dispensed by the School doctor or nurse.)*

5) **Does the child have any present illness:**  No  Yes

**Describe:**

**Health History:**

Please indicate if your child has had any of the following conditions. If the answer is yes to any, please give details below.

	No	Yes	Age		No	Yes	Age
Diabetes				Scoliosis			
Meningitis				<b>Skin Diseases</b>			
Tuberculosis				Psoriasis			
Fainting Spells				Vitiligo			
ADD / ADHD				Atopic Dermatitis			
Heart Disorder				Impetigo			
Urinary Disorder				<b>Other Illness/Condition</b>			
Epilepsy							

**Describe:**

**Hospitalization, Serious Injuries/Illness?(Please give details.)**

**Eye glasses or contact lenses:**  No  Yes

**Eye or vision problems, describe:**

**Hearing problem(s)/ multiple ear infections:**  No  Yes

**Describe:**

## IMMUNIZATION RECORD

To be filled in by parents. Please attach or complete schedule below, including dates for childhood vaccinations.

**Student's Name:** \_\_\_\_\_

	<i>Family Name</i>	<i>First Name</i>	<i>Middle Name</i>		
TYPE	DATE	DATE	DATE	DATE	DATE
<b>The following immunizations are mandatory and must be current before a student may enter class.</b>					
DPT / DT	2 mo*:	4 mo*:	6 mo*:	15-18 mo*:	4-6 yrs*:
Polio	2 mo*:	4 mo*:	6-18 mo*:	4-6 yrs*:	
Measles	12-15 mo*:	4-6 yrs*:			
Mumps	12-15 mo*:	4-6 yrs*:			
Rubella	12-15 mo*:	4-6 yrs*:			
<b>The following immunizations are strongly recommended.</b>					
Covid - 19 (may become mandatory)					
Tetanus booster (between ages 12-15)					
Hepatitis A					
Hepatitis B					
Varicella (chickenpox)					

\* Recommended international standard

## TUBERCULOSIS SCREENING CHECKLIST

Do any of the following conditions or situations apply to you or your child?

- a) A persistent cough (three weeks or more), fever, night sweats, fatigue, loss of appetite, or weight loss? YES  NO
- b) Lived with or been in close contact to a person known to be or suspected of being sick with TB? YES  NO
- c) Lived, worked, or volunteered in any homeless shelter, prison/jail, hospital or drug rehabilitation unit, nursing home or residential healthcare facility? YES  NO

If the answer to any of the above is **YES**, please see Tuberculosis Screening Section on page 4.

## AUTHORIZATION

I give consent for my child to receive the following:

- \*1. Minor first aid (at the clinic) YES  NO
- \*2. Emergency care (at the clinic) YES  NO
- \*3. Emergency care (at hospital Emergency Room) YES  NO
- 4. Oral non-prescription medication YES  NO

**\*NOTE: If "NO" to 1,2, and/or 3 above, the student may not enter school until a meeting is set with the School Health Clinic.**

I hereby authorize the ISM designated Dentist to give the following dental treatment to my child, as the need arises:

- Emergency dental examination YES  NO
- Emergency dental treatment YES  NO

*Permission is hereby given for emergency measures to be initiated in case of accident or sudden illness with the understanding that I will be notified as soon as possible.*

*I certify that all information given on this card is complete and correct.*

*I acknowledge that it is my responsibility to inform the ISM School Health Clinic of any changes in my child's health, physical condition or medical needs.*

*In order to comply with a new government law on data privacy, we are now obliged to ask for parents' permission to collect, process and store all personal data. When you tick the box below, you are giving formal consent for this to happen.*

- Yes – I give my consent to ISM to process my personal information and sensitive personal information for the purpose(s) described in the ISM Privacy Policy found in [www.ismanila.org](http://www.ismanila.org) > Student Services > Technology at ISM.
- No – I do not give my consent to ISM to process my personal information and sensitive personal information for the purpose(s) described in the ISM Privacy Policy found in [www.ismanila.org](http://www.ismanila.org) > Student Services > Technology at ISM. I understand that this effectively rescinds my application.

Parent/ Legal Guardian's Name: \_\_\_\_\_

Parent/ Legal Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PHYSICAL EXAMINATION – To be completed by a Licensed Physician.

This form is mandatory for school admission and must be completed no more than 12 months before expected start date.

**Student's Name:** \_\_\_\_\_  
*Family Name*
*First Name*
*Middle Name*

**Height (cm)** \_\_\_\_\_ **Weight (kg)** \_\_\_\_\_ **Blood Pressure** \_\_\_\_\_ **Vision: R** \_\_\_\_\_ **L** \_\_\_\_\_ **Both** \_\_\_\_\_ **Blood type** \_\_\_\_\_  
(optional)

Please review the following areas:	Normal	Findings	DESCRIPTION (Attach additional sheets if necessary)
1. Head, Eyes, Ears, Nose, Throat			
2. Respiratory			
3. Cardiovascular			
4. Gastrointestinal			
5. Hernia			
6. Genitourinary			
7. Musculoskeletal			
8. Metabolic/Endocrine			
9. Neuropsychiatric			
10. Skin			
11. Mammary			

**Describe Findings:**

**Comments:**

An ECG (12-lead resting electrocardiogram) is **REQUIRED** for all new students entering Grade 6 and above.

**Diagnosis:**    age appropriate ECG    further cardiological diagnostic required    pathological heart condition

**Findings:** \_\_\_\_\_

If further tests are required, please submit findings along with this form.

**Remarks:** \_\_\_\_\_

**TUBERCULOSIS SCREENING**

**ATTENTION HEALTH CARE PROVIDER:** Please refer to the Tuberculosis Screening Checklist on page 3. If the answer to any of the questions is YES, proof of PPD skin test is required. If the student has a history of a positive PPD test or if PPD result is positive a chest x-ray is **REQUIRED**. PPD and/or chest x-ray must be done within one calendar year prior to admittance. History of BCG vaccination does not exclude the student from PPD skin testing.

**PPD Skin Test**

Date Given: _____ mm diameter: _____	Date Read: _____ Test Result: _____
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**CHEST X-RAY**

Required for those with a positive skin test, history of a positive skin test or history of tuberculosis infection.

Date of x-ray: _____	Result of x-ray: _____
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If negative CXR and positive PPD, did student complete a course of treatment?      **YES**  **NO**

If yes, how many months did the treatment last? \_\_\_\_\_ (# of months)

Physician's Printed Name	Signature and Title	License Number	Date
Address	Office Phone Number		