Little Clarion Montessori School

4th floor, Alco Building, 391 Senator Gil Puyat Avenue,Makati City, M.M. Philippines
(632)890-8840

STUDENT HEALTH CARD AND PHYSICAL EXAMINATION RECORD

PLEASE PRINT THE INFORMATION REQUESTED BELOW

Student and Family Information

Student's Name: _____ **Preferred Name:** _____
Family Name First Name Middle Name

Gender: M / F **Date of Birth:** _____/_____/_____ **Nationality:** _____
mm dd yyyy

Student resides with: ❑ **Both Parents** ❑**Father** ❑**Mother** ❑ **Guardian**

FATHER / GUARDIAN'S NAME:

_____

Home Address: _____

_____

Home Phone #: _____

Cell Phone #: _____

Direct office line #: _____

Office Phone #: _____

Company Name: _____

Languages Spoken: _____

MOTHER / GUARDIAN'S NAME:

_____

Home Address: _____

_____

Home Phone #: _____

Cell Phone #: _____

Direct office line #: _____

Office Phone #: _____

Company Name: _____

Languages Spoken: _____

For Emergency (If Parents Cannot Be Reached)

Primary Contact: _____ **Phone #:** _____ **Cell #:** _____

Secondary Contact: _____ **Phone #:** _____ **Cell #:** _____

Local Doctor or Health Care Provider: _____ **Phone #:** _____

NOTE: Please notify the Admission Office of any changes in phone numbers or contact persons

Medical Information & History

Allergies? ❑ No ❑ Yes **What is the allergy to? (foods, drugs, etc.)**_____

Reaction: _____

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

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 School Health Clinic and the medication/s kept in the Clinic to be dispensed by the School doctor or nurse.)

Does the child have any present illness: ❑ No ❑ Yes **Describe:**_____

Health History:

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

	No	Yes	Age		No	Yes	Age
Skin Problem				Asthma			
Diabetes				Heart Disorder			
Meningitis				Urinary Disorder			
Tuberculosis				Epilepsy			
Fainting Spells				Scoliosis			
ADD / ADHD				Other Illness			

Describe: _____

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

Eye glasses or contact lens: ❑ *No* ❑ *Yes* **Eye or vision problems, describe:** _____

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

Physical Examination – Mandatory for School Admission *To be completed by Licensed Physician*

Height (cm) **Weight (kg)** **Blood Pressure**_____ **Vision: R** _____ **L Both** _____

Blood type, if known_____

Please review the following areas:	Normal	Abnormal	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: _____

_____

Able to participate in physical education activities: ☐ *No* ☐ *Yes*

Restricted from certain sports: _____

Immunization Record **Please attach or complete schedule below, include dates for childhood vaccinations**

The following immunizations are mandatory and must be current before a student may enter class

TYPE	DATE	DATE	DATE	DATE	DATE
DPT / DT					
Polio					
Measles					
Mumps					
Rubella					
The following immunizations are strongly recommended					
Typhoid injection / oral every 3 years					
Tetanus booster (between ages 12 – 15)					
Hepatitis A					
Hepatitis B					
Varicella (chickenpox)					

_____

Printed Name **Signature and Title** **License Number** **Date**

_____

Address **Office Phone Number**

AUTHORIZATION

In case of emergency, I give consent for my child to receive emergency care at the hospital Emergency Room. 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 Little Clarion International School of any changes in my child's health, physical condition or medical needs.

Parent's Name: _____

Parent's Signature: _____ Date: _____