School Clinic Records Medical Form *(to be completed by parents)*

APPLICANT INFORMATION

NAME (as appears in passport)

Last	First	Middle

Preferred Name	Date of Birth (mm/dd/yyyy)	Citizenship	Gender

Home Address	Home Telephone

PARENT/GUARDIAN INFORMATION

☐ **Father** ☐ Stepfather ☐ Legal Guardian 1		☐ **Mother** ☐ Stepmother ☐ Legal Guardian 2	
Last Name:		Last Name:	
First Name:		First Name:	
Middle Name:		Middle Name:	
Office Phone Number:		Office Phone Number:	
Mobile Number:		Mobile Number:	
Email Address:		Email Address:	
Emergency Contact Person (aside from above)		**Emergency Contact Person (aside from above)**	
Name:		Name:	
Mobile Number:		Mobile Number:	

Who is the custodial parent / guardian?	☐ Father / Guardian 1	☐ Mother / Guardian 2	☐ Both
To whom should correspondence with school clinic be sent?	☐ Father / Guardian 1	☐ Mother / Guardian 2	☐ Both

PAST HISTORY *(Please check if the child has a past history of the following diseases, please provide the date and age)*

Illness	*Date*	*Age*	*Illness*	*Date*	*Age*
☐ Asthma			☐ Measles		
☐ Chicken Pox			☐ Meningitis		
☐ Chronic Ear Infections or Otitis Media			☐ Mumps		
☐ Diabetes			☐ Primary Complex		
☐ Epilepsy			☐ Rubella		
☐ Fainting Spells			☐ Scoliosis		
☐ Febrile Convulsions			☐ Skin Problems		
☐ Heart Disorder			☐ Urinary Tract Infections		
☐ Hepatis A			☐ Whooping Cough		
☐ Hepatits B			☐ Others		

Medication/s taken on a regular basis:

Please indicate if the child has any allergies.

☐ Food_____ ☐Medicine_____ ☐Others _____

AUTHORIZATION

I give consent for my child to receive the following:

First aid treatment at the school clinic ☐ YES ☐ NO Non-prescription medicine in case of emergency ☐ YES ☐ NO

I acknowledge that it is my responsibility to inform the Beacon Academy clinic of any update in my child's medical records.

Parent's/ Guardian's Name and Signature_____ Date _____

Physical Examination *(to be completed by a licensed physician no more than 12 months before acceptance)*

Applicant's Name_____ Date : _____

LAST FIRST MIDDLE

Height (cm)	Weight (kg)	BP	Pulse	Vision-R	Vision-L	Vision- Both	Heart Screening	Blood Type

	Abnormal	Normal			Abnormal	Normal			Abnormal	Normal			Abnormal	Normal
Eyes				**Throat**				**Lungs**				**Skin**		
Ears				**Neck**				**Heart**				**Posture**		
Nose				**Nodes**				**Abdomen**				**Joints**		

STUDENT IMMUNIZATION RECORDS *(Please attach or complete schedule below)*

Type	Date 1st	Date 2nd	Date 3rd	Date	Date	Date
BCG (Tubercolosis)						
DPT (Diptheria, Petusis/ Tetanus)						
OPV/ IPV (Polio Vaccine)						
HIB (Haemophilous Influenza B)						
Hepatitis B						
Hepatitis A						
MMR (Measles, Mumps, Rubella)						
Varicella (Chicken Pox)						
Typhoid						
Cholera						
Tetanus						
Others						

STUDENT'S MEDICINES AND ADDITIONAL INFORMATION

	Name	***Dosage***		***Name***	***Dosage***
colds			headache		
cough			fever		
allergies			asthma		

Medication/s taken on a regular basis:

Has the child been hospitalized? ☐YES ☐NO If yes, please give details (including year):

Is the child able to participate in physical education activities? ☐YES ☐NO

Please indicate any specific medical condition of which the school should be aware:

Comments:

Other relevant information:

Printed Name of Physician:	Signature:	License No.	Date:
Address:			Office Telephone