JUNIOR HIGH SCHOOL
SILLIMAN UNIVERSITY
Building Competence, Character & Faith

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's/ward's past illnesses, immunizations, surgeries if any, and other health information that may be relevant to your child's/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

STUDENT'S DEMOGRAPHIC DATA

Name: _____ Grade Level: _____
Last First Middle
Date of Birth: _____ Place of Birth: _____
Gender: _____ Religion: _____ Nationality: _____
Address: _____ Home Phone No.: _____

Name of Parents:
Father's Name: _____ Mother's Name: _____
Contact No.: _____ Contact No.: _____
Email Address: _____ Email Address: _____

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 can't be reached:
Name: _____ Contact No.: _____
Name: _____ Contact No.: _____

STUDENT'S 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 conditions, 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 ongoing treatment for any medical, surgical, or psychological condition? ___ No ___ Yes (Pls give details) _____
_____

4. Is there any reason why your child/ward cannot participate in Physical Education, classes or in any school related activities? ___ No ___ Yes (Pls give details) _____
_____
Note: Please submit a medical certificate for diagnosed health conditions and limitations of school related activities.

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STUDENT'S 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)		
1ST dose					
2nd dose					
Booster					

The following are the list of medications that are usually administered by the Clinic Personnel based on the student's health condition. Please note down any known allergy to these medications and the specific reactions your child/ward may manifest. If none, please write **OK** on the column provided for:

MEDICINE	OK / REMARKS
For nasal decongestion: **Phenylephrine + paracetamol (NEOZEP NON-DROWSY)** 10mg/500mg; **Phenylpropanolamine + paracetamol** (**DECOLGEN NO DROWSE)** 25mg/500mg	
For allergies: **Loratadine (ALLERTA)** 10mg/tab	
For fever and headaches: **Paracetamol (BIOGESIC/TEMPRA)** 500mg/tab	
For menstrual cramps & other pains: **MEFENAMIC ACID (PONSTAN SF)** 500mg/cap	
For asthma: **Salbutamol (ASMALIN)** 2.5mg/neb	
For loose bowel movements, vomiting & dehydration: **HYDRITE SOLUTION**	
For hyperacidity: **Aluminum hydroxide + Magnesium hydroxide + Simethicone (KREMIL-S)**	
For sore throat: **STREPSILS Lozenge; ORAHEX-AF Oral Rinse**	

WAIVER

I/We, the undersigned, give permission for my/our child/ward to be given the above-mentioned over-the-counter medication by the school nurses. I/We also authorize the officials of SUJHS to contact directly the persons indicated on this Student Health Form and do authorize the clinic personnel to render first aid treatment as may be considered necessary for the health of my/our child/ward. In the event that the parents or other persons named cannot be contacted, the school officials are authorized to take whatever action **is** considered necessary in their judgment. I/We will not hold the school financially responsible for the emergency care and utilization of public utility vehicles as necessary.

I/We also authorize the school clinic nurses to disclose and share relevant health information (e.g., medical conditions, allergies, medications, and any other vital health details) with my/our child's teachers and other appropriate school personnel to safeguard my/our child's well-being during school hours.

_____
PARENT(S)/LEGAL GUARDIAN'S SIGNATURE OVER PRINTED NAME
DATE SIGNED: _____