



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.

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
The following immunizations are mandatory and must be current before a student may enter class.					
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*:			
The following immunizations are strongly recommended.					
Tetanus booster (between ages 12-15)					
Hepatitis A					
Hepatitis B					
Varicella (chickenpox)					
Japanese Encephalitis					
Covid - 19					

* 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 > 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 > 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: _____ Far Vision: R _____ L _____ Near Vision: R _____ L _____ 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. Neurological			
10. Psychiatric/ Attention Disorder			
11. Skin			

Describe Findings:

Comments:

A cardio clearance, based on an ECG (12-lead resting electrocardiogram) is REQUIRED for re-enrolling students entering Grade 6 to ensure they are fit for physical activities (PE).

If the ECG is not within normal range or age-appropriate, a pediatric cardiologist must clear the student for PE, or set remarks before the student can participate (see below).

Diagnosis: ECG within normal range further cardiological diagnostic required

Findings: _____

Remarks/restrictions: _____

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	