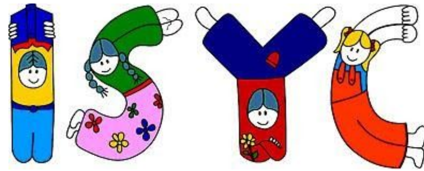

Integrated School
for Young Children

SCHOOL HEALTH RECORD

School Year **2020 - 2021**

Dear Parents:

A complete Health History and Physical Examination are required for your child's admission to ISYC. This form is to be filled out by a parent or guardian. Please have your family physician fill out pertinent data. Thank you.

A. Health History

1. Time of Delivery (Please check) _____ Premature _____ Due _____ Overdue
2. Type of Delivery (Please check) _____ Natural _____ Caesarean _____ Forceps
3. Weight of your child at birth ____________ lbs.
4. Did your child contract any disease before birth (congenital disease)? _____ Yes_____ No
   If yes, please specify. ____
5. Did your child contract any disease after birth (infantile disease)? _____ Yes _____ No
   If yes, please specify. ____
6. Does your child suffer from any recurring illness or problem which may need special attention or which may hamper his school performance?
   ______ Eye Defect
   ______ Asthma
   ______ Sinusitis
   ______ Ulcers
   ______ Allergy (Please specify: _____________________________)
   ______ Others (Please specify: _____________________________)
7. Does your child take prescribed medicine/s?_____ Yes _____ No
   If yes, please specify. ____
8. What is your child's usual bedtime? ____________________ Waking time? _________________
   Has your child had any problem with nightmares? _______ Bedwetting? _______________
   How did you help him? ____
9. What are your concerns about your child's health/physical development?
   ____
   ____

10. Has your child undergone any psychological assessment? ______ Yes ______ No
    If yes, for what purpose? ____

11. Is your child attending any form of therapy? ______ Yes _______ No
    If yes, please give details regarding the purpose, frequency, etc. of therapy sessions.
    ____
    ____

B. Immunizations:

Please write corresponding dates of immunization:	1	2	3	Booster #1	Booster #2
BCG	________	________	________	________	________
DPT	________	________	________	________	________
OPV/IPV	________	________	________	________	________
HEPATITIS B	________	________	________	________	________
HIB	________	________	________	________	________
MEASLES	________	________	________	________	________
MMR	________	________	________	________	________
TYPHOID	________	________	________	________	________
HEPATITIS A	________	________	________	________	________
VARICELLA VACCINE	________	________	________	________	________
OTHERS	________	________	________	________	________
TUBERCULIN TEST	________	________	________	________	________

C. PHYSICAL EXAMINATION BY FAMILY PHYSICIAN

Vital signs: HR ________ RR ________ BP ________ T^0 ________
Height ______________ Weight ______________
Scalp ____
Eyes _____________________ _____________________
OS OD
Ears _____________________ Nose _______________
Mouth ____
Neck/Lymph Nodes ________________________________
Chest-Heart _____________________________________
Lungs ____
Abdomen _______________________________________
Extremities ______________________________________
Genito-Urinary ___________________________________
Neurologic Exam _________________________________
Reflexes ____

____
Date of Examination

____
Name and Signature of Physician
License No. ________________________

D. PARENTAL CONSENT

1. May the Teacher-in-charge administer treatment as medical needs indicate? _____ Yes _____ No

2. If ***emergency*** treatment is necessary, may the school authorities take the child to the nearest doctor or hospital before calling the parents? _____ Yes _____ No.
   If "YES", please give the name of preferred hospital, doctor and telephone number.

____

If the student's activities should be restricted in any way, the parent must advise the school directress in writing.

If any special medication is to be given to the student at school, the parent must send a supply of medicine with written instructions for use, signed by the attending physician or parent.

____

Parent's name and signature/ Date