Ateneo de Manila University
Loyola Heights, Quezon City

Loyola Schools Office of Health Services (LSOHS)

STUDENT HEALTH RECORD

PLEASE WRITE IN INK

SY 2017-18

1 X 1

PHOTO

Name: _____ Age: _____ Sex: _____
Last *First* *Middle*

ID No.: _____ Course: _____ Nickname: _____ Mobile No.: _____

Date of Birth: _____ Place of Birth: _____ Civil Status: _____ Email add: _____

The Loyola Schools Office of Health Services wishes to provide the best environment that will ensure the student's holistic formation. This includes providing them with suitable services inside the campus. In this regard, we request that you provide us with your accurate and up-to-date health information.
All information supplied in this health record will be kept confidential and will only be used to ensure that professional services provided to students in the campus are relevant, appropriate and supportive.

Permanent Address: _____
_____
Current Address: _____
_____
Tel. Number: _____
☐ Dormer ☐ Non-Dormer
☐ If dormer, please specify
Address:_____
Contact Person/Care taker/Landlord:_____
Phone no:_____

MOTHER'S CONTACT INFORMATION:
Name: _____
Civil Status: ☐ single ☐married ☐separated ☐widow
Home Address: _____
_____
Occupation: _____
Office Address:_____
Office Contact No. _____
Mobile No.: _____ Phone No.: _____

FATHER'S CONTACT INFORMATION:
Name: _____
Civil Status: ☐ single ☐married ☐separated ☐widow
Home Address: _____
_____
Occupation: _____
Office Address:_____
Office Contact No. _____
Mobile No.: _____ Phone No.: _____

GUARDIAN'S CONTACT INFORMATION or*whom to notify in caseof emergency if above is unavailable.*Preferably within Metro Manila**.(Required)**
Name: _____
Civil Status: ☐ single ☐married ☐separated ☐widow
Home Address: _____
_____
Occupation: _____
Office Address: _____
Office Contact No. _____
Mobile No.: _____ Phone No.: _____
Relationship to student: _____

Do you have a family or regular doctor? ☐YES ☐NO
Name: _____
Address: _____
Mobile No.: _____
Phone No.: _____

HISTORY OF ALLERGIES:

Do you have any allergy to medicines or food?
Please specify:
_____
_____
_____
_____
_____

Do you carry medical hospital insurance?☐YES ☐NO
If yes, name of company:
_____
_____
_____

CERTIFICATION AND PERMISSION FOR TREATMENT

The information given above is accurate to the best of my knowledge. I am aware that inaccuracies and omissions may compromise the care that I may receive from the Loyola Schools. I also understand that the information contained in this health record will be used solely to provide the appropriate services that I may need while in the Loyola Schools.

I hereby grant permission to the medical professionals of the Loyola Schools Office of Health Services (LSOHS) to evaluate, treat, or refer me to an outside health facility, in case of emergency illness or injury while in the Loyola Schools at my expense. This permission is given to avoid delay in giving the appropriate treatment when medical problems arise. I understand that all efforts will be exhausted to inform me of any such events requiring tertiary care.

Printed Name & Signature:

_____

Date Signed: _____

Section 2: Personal and Family History

Please check if you or your siblings, parents or grandparents has/have or had any of the following:
This section needs to be reviewed by the physician. [Legend: STU-Student (You) SIBS-Siblings PAR-Parents GPS-Grand Parents]

If any of the following has been confirmed for the student, please provide details below. For any **active conditions***, a medical certificate with an update of the current status of the student is required*._____
_____
_____
_____

ILLNESS	STU	SIBS	PAR	GPS
Allergy, Hives (Specify)				
Allergic Rhinitis				
Asthma(Date of Last Attack)				
Tuberculosis				
Other Lung Problems (Specify)				
Hypertension or High Blood				
High Cholesterol, Lipids or Fats				
Stroke or Heart Disease before the age of 40 yrs. Old				
Other Hearth Disease before the age of 40 yrs. old				
Anemia				
Bleeding Problems				
Thyroid Problems				
Diabetes				
Hepatitis/ Jaundice				
Other Liver Problems (Specify)				
Acid Peptic Disease/ Ulcers				
Other Stomach/ Intestinal Problem (Specify)				
Kidney or Urinary Problems (Specify)				
Dizziness/ Fainting				
Recurrent Headache/ Migraine				
Convulsions or Seizures				
Eating or Nutritional Problems				
Alcohol or Drug use				
Depression				
Suicidal Thoughts				
Other psycho-emotional Problems				
Cancer (Specify)				
Surgeries Undertaken (Specify)				
Any Other Active medical conditions (Specify)				

History of Confinement: (Pls. specify date, diagnosis, and any pertinent details.)
_____
_____
_____
_____
_____
_____

Smoking History – Please encircle answer:
Are you a CURRENT or PREVIOUS smoker? NEVER?
Age of onset of smoking:
_____
How many sticks per day? _____

For Female Students:
Menarche: _____
Last Menstrual Period: _____
OB Score (if with previous pregnancy): _____

Do you currently have special needs that can affect your academic performance or social adjustment in the University?
___ Yes ___ No

If yes, what are these? *Please check the appropriate space and kindly specify the condition.*

___ Physical limitations (e.g. Cerebral palsy, paraplegia, problems with ambulation, heart problems, others)
Please specify: _____

___ Emotional or behavioral conditions (e.g. obsession-compulsion, personality problems, anxiety, depression, Asperger's syndrome, others)
Please specify: _____

___ Conditions related to attention or concentration (e.g. ADHD, others)
Please specify: _____

___ Ongoing or long-standing medical conditions (e.g. seizures or epilepsy, diabetes, others)
Please specify: _____

Are you receiving professional services for this condition?
___ Yes ___ No

If yes, may we ask your permission to contact the health professional so we can coordinate with him/her the care and services for you if it is necessary? ___ Yes ___ No

Name of Health Professional: _____
Field of Specialization: _____
_____
Office Address: _____
Office Contact No. _____
Mobile No.: _____ **Phone No.:** _____

For any of the conditions above, please specify details and provide any documentation/work-up and clearance from your certified healthcare provider.

Current medicine being taken:
_____
_____
_____
_____