

MEDICAL HEALTH INFORMATION
For SY 2026-2027

1. General Information

Name : _____

(English) Last NameFirst NameMiddle Name(Chinese)

Level Applied for:

Toddler Nursery

Kinder G1

G2 G3

G4 G5

G6 G7

G8 G9

G10 G11

Residence : _____

Contact Numbers: _____

Birth date : _____Age: _____Sex: _____

Height: _____Weight: _____

2. Medical History:

Item Condition	AGE	DATE	MX / DX	Hospital / Clinic
2.1 Medical (e.g.sight, hearing, speech)				
2.2 Surgical				
2.3 Allergies				
2.4 Medication				

3. Immunization: Please check the completed immunizations:

Primary:

BCG

1st dose _____

2nd dose _____

3rd dose _____

Booster _____

Hepatitis B

1st dose _____

2nd dose _____

3rd dose _____

Booster _____

DPT

1st dose _____

2nd dose _____

3rd dose _____

Booster 1 _____

Booster 2 _____

OPV / IPV

1st dose _____

2nd dose _____

3rd dose _____

Booster 1 _____

Booster 2 _____

H. Influenza B

1st dose _____

2nd dose _____

3rd dose _____

Booster _____

Measles

MMR 1 _____

MMR 2 _____

Chicken Pox 1 _____

Chicken Pox 2 _____

Hepatitis A

1st dose _____

2nd dose _____

3rd dose _____

OPTIONAL:

Typhoid1

1st dose _____

2nd dose _____

3rd dose _____

Pneumococcal

Meningococcal A + C _____

Flu _____

Tuberculin Test _____

Others, specify _____

I hereby certify that I have examined personally _____
and I have found him / her to be physically fit to attend school and participate in all its regular activities and programs .

Remarks : _____

Office / Clinic Address

Physician's Signature Over Printed Name / Date

Office / Clinic Contact Numbers

License Number