



# Ateneo de Zamboanga University

SENIOR HIGH SCHOOL  
SCHOOL INFIRMARY

www.adzu.edu.ph  
ADZU SHS Infirmary  
062-991-0871 loc no 3041



PASTE  
STUDENT'S  
RECENT 1X1  
PHOTO HERE

## STUDENT'S HEALTH INFORMATION | SY \_\_\_\_\_

To be accurately completed by Parents/Guardians. All information contained within will be kept confidential, following the university's data privacy policy.

### STUDENT INFORMATION

Name \_\_\_\_\_  
(Last) (Given Name) (Middle)

ID Number: \_\_\_\_\_ Grade & Sec.: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Number: \_\_\_\_\_

\_\_\_\_\_ Mobile Number: \_\_\_\_\_

### CONTACT INFORMATION

	MOTHER	FATHER	EMERGENCY CONTACT/S If parents cannot be reached	
NAME			NAME	NAME
ADDRESS (if different from above)			CONTACT NO	CONTACT NO
HOME NO			MEDICAL CARE PROVIDER	DENTAL CARE PROVIDER
WORK NO			NAME	NAME
MOBILE NO			CONTACT NO	CONTACT NO
EMAIL				

### MEDICAL/HEALTH HISTORY

MEDICAL CONDITION	NO	YES	If YES, please explain (Attach additional sheet if necessary)
1. Allergies (type)			
2. Asthma			
3. Other Respiratory Illnesses			
4. Cardiac Diseases			
5. Hypertension			
6. Diabetes Mellitus			
7. Seizure Disorders/Epilepsy			
8. Other Neurological Conditions			
9. Musculoskeletal Disorders-Fine/gross motor deficit			
10. Vision Disorders			
11. Hearing Disorders			
12. Speech/Language Disorders			
13. Emotional/Behavioral Disorders			
14. Other Illnesses			
Regular prescription or OTC medication			
Surgical Operation/s			
Accidents (sports/non-sports related injury)			
Undergone psychiatric assessment or treatment for the past 5 years?			
Have been in close contact to a known COVID-19 (+)			

### PRIVACY CONSENT

I declare that all the information contained herein is correct to the best of my knowledge. I understand that all of the written information will solely be used for the medical and dental services provided by the Senior High School Infirmary and other health-related concerns of the student whose name is indicated above. I further allow my child/ward to be referred to the Guidance Office and Office of Student Services and other medical specialist, if needed.

All information provided are confidential and shall not be copied, shared, distributed, and used for any other purposes unless stated by the school physician, school nurses, parent/s or legal guardian whose name is indicated here and/or required by the law.

\_\_\_\_\_  
Parent's/Guardian's Signature Over Printed Name

\_\_\_\_\_  
Relation to Student

\_\_\_\_\_  
Date



Please submit completed form to SHS Infirmary or send in through direct message to  
ADZU SHS Infirmary FB page or email to manacladb@adzu.edu.ph