Ateneo de Zamboanga University
SENIOR HIGH SCHOOL
SCHOOL INFIRMARY
Ground floor, FWS Building, La Purisma Street, Zamboanga City 7000 | (62) 991-0871 local 3041
adzu.edu.ph | ADZU SHS INFIRMARY | shsinfirmary@adzu.edu.ph

1 x 1 picture

STUDENT's HEALTH & ORAL EXAMINATION RECORD

ID No.:

NAME: Last First Name M.I.	Date of Birth:	Place of Birth:
Name of Parent/s or Guardian:	Religion:	Gender:
Address in ZC:	❑ Grade 11 ❑ Grade 12	
In case of emergency , parents'/guardian's contact no.: / Student's Mobile number:	Strand & Section: _____	

Medical History:

Please Check:	Yes	No	Specify
Allergy (type)			
Asthma			
Other Respiratory Illness			
Diabetes			
Epilepsy/Seizure Ds			
Fainting			
Fracture			
Head Injury			
Heart Ailment			
Hyperventilation			
Hypertension			
Kidney Disease/UTI			
Vision/Hearing Disorder			
Psychiatric Assessment			
Other Illnesses			

Immunization: (Please check)

BCG	
DPT	
OPV	
MMR	
HIB	
Hepa B	
Chicken Pox	

Blood Type: ____

❑ I **allow** my child to be given medicines in school.

❑ I **DO NOT** allow my child to be given medicines in school.

In case of emergency, please indicate hospital of choice:

_____

Family Physician: _____

Any special instructions, please specify:

_____

COVID VACCINATION DETAILS - (Please submit copy of COVID Immunization Certificate/Card)

FIRST DOSE	SECOND DOSE	BOOSTER
Vaccine name:	Vaccine name:	Vaccine name:
Date:	Date:	Date:
Complete Facility Address:	Complete Facility Address:	Complete Facility Address:

PRIVACY CONSENT

I declare that all the written personal and health information above are true and 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 specialists. All information provided are confidential and shall not be copied, shared, distributed, and used for any other purposes unless stated by the school doctor, 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 & vaccine card to SHS Infirmary before enrollment or on or before your scheduled Medical & Dental check-up

FOR INFIRMARY USE ONLY

STRESS TEST for PE/SPORTS

DATE									
	BP	P	O^2S	BP	P	O^2S	BP	P	O^2S
Resting									
Training									
Recovery									
Physician's Approval									

(For School Physician)

Student may participate in:

Competitive Sports YES___ NO___
Regular P.E. YES___ NO___
Limited P.E. only YES___

_____
School Physician's Signature

***BMI*:** kgs ÷ [(cm/100)*2]

<18.5 – Underweight
18.5-24.9 – Healthy
25-29.9 – Overweight
30-34 – Obese Class 1
35-39.9 – Obese Class 2
>40 – Obese Class 3

MEDICAL

Date Examined			
Height		Mouth	
Weight		Tonsils	
Posture		Nose	
Nutrition		Throat	
Pediculosis		Heart	
Vision:		Lungs	
w/ Glasses	L R	Abdomen	
w/o Glasses	L R	Skin	
Ears		Blood Pressure	
	PR:	O_2SAT	
REMARKS			

Physician's Signature

DENTAL

Date Examined

Oral Health Status

Dental Carries		P. Teeth Present		T. Teeth Present	
Gingivitis/Periodontal		P. Sound Teeth		T. Sound Teeth	
Debris		Decayed Teeth (D)		decayed teeth (d)	
Calculus		Missing Teeth (M)		filled teeth (f)	
Abnormal Growth		Filled Teeth (F)			
Cleft Lip/Palate		Total DMF Teeth		Total df Teeth	
Others					

LEGEND: *(For Oral Health Condition)*
Sound - ✓ Decayed - **D/d** Filled - **F/f** Missing - **M/m**
Sealant - **S** Unerupted - **Un/un** Jacket Crown - **JC/jc** Pontic - **P/p**

(CAPITAL LETTERS shall be used for recording the condition of permanent dentition and SMALL LETTERS for the status of temporary dentition)

Services Monitoring Chart **(Sealant/PF/TF/Exo)**

Date: _____

			55	54	53	52	51	61	62	63	64	65			
18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38
			85	84	83	82	81	71	72	73	74	75			

S - Sealant **PF** - Permanent Filling (composite, Am/ART)
TF - Temporary Filling **X** - Extraction **O** - Others

Oral Health Condition

			55	54	53	52	51	61	62	63	64	65			
18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38
			85	84	83	82	81	71	72	73	74	75			

Dentist's Signature

SUMMARY of SERVICES RENDERED

Date	Tooth No	Oral Prop	Temp Filling	Perm Filling	Sealant	Exofoliant	Consultation	Others	Remarks	Signature

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