CHINESE INTERNATIONAL SCHOOL MANILA

Upper McKinley Rd., McKinley Hill
Fort Bonifacio 1634, Taguig City
+63(2) 798-0011 or +63(917) 798-0011
clinic@cismanila.org
www.cismanila.org

MEDICAL FORM

DATE OF APPLICATION

________/______/________
MONTH / DAY / YEAR

STUDENT INFORMATION

Name	Date Of Birth	Gender
LAST NAME FIRST NAME MIDDLE NAME	MONTH DAY YEAR	☐ MALE ☐ FEMALE

HEALTH HISTORY (To be completed by Parent/Guardian)
To the best of your knowledge has your child had any problem(s) with the following?
If 'Yes', please indicate the year in the 'Yes' column. Otherwise, write N/A.

Acute Condition	Yes (year)	Pertinent Information	Chronic Condition	Yes (year)	Pertinent Information
Chicken Pox			Bladder Problem		
Diphtheria			Blood Disorders		
Head Injury			Heart Problems		
Hepatitis			Diabetes Mellitus		
Measles			Epilepsy / Seizures		
Meningitis			Fainting Spells		
Mumps			Frequent Gastric Problems		
Pneumonia			Frequent Headaches		
Poliomyelitis			Hearing Problems		
Rheumatic Fever			Serious Accidents		
Rubella			Skin Problem		
Scarlet Fever			Thalassaemia/G6PD		
Tuberculosis			Scoliosis		
Whooping Cough			Vision Problems		
Other			Other		

Does your child wear eye glasses or contact lenses? ☐ Yes ☐ No

Does your child have allergies? ☐ Yes ☐ No

If yes, what is the allergy to? ______________________________

Reaction: ______________________________

Treatment: ______________________________

Does your child have asthma? ☐ Yes ☐ No

If yes:

Does your child carry an asthma inhaler? ☐ Yes ☐ No

Has your child been brought to a hospital in the past year for control of asthma attack? ☐ Yes ☐ No

What medication/s for asthma is your child taking at this time? ______________________________

Has your child undergone medical treatment/
Been hospitalized within the last 3 years? ☐ Yes ☐ No

If yes:
Date and reason for medical treatment/hospitalization:____

Are there any other health condition(s) that the school should be aware of (e.g. diabetes, epilepsy, etc.)?
____
____

IMMUNIZATION RECORD (Please complete the following section or attach a copy of the immunization record/card of the student) The following immunizations are mandatory:

TYPE	DATE	DATE	DATE	DATE	DATE	DATE
DPT/DPT Booster						
OPV/OPV Booster						
Measles						
Mumps						
Rubella						
Polio						

The following immunizations are recommended:

TYPE	DATE	DATE	DATE	DATE	DATE	DATE
Typhoid						
Tetanus Booster						
DPT/DPT Booster						
Hepatitis A						
Hepatitis B						
Varicella						
Other vaccinations						

AUTHORIZATION
I give consent for my child to receive the following:

1. First aid at the clinic? ☐ Yes ☐ No
2. Emergency care at the clinic? ☐ Yes ☐ No
3. Emergency care at St. Luke's Medical Center Global City or any nearby hospital at CISM discretion (for field trips)? ☐ Yes ☐ No
4. Oral non-prescription medicine? ☐ Yes ☐ No

NOTE: If "NO" to 1, 2, or 3, emergency care instructions must be detailed and submitted to the CISM Clinic.

Permission is hereby granted for emergency measures to be initiated in case of accident or illness with the understanding that at least one parent or guardian will be notified as soon as possible. Emergency care at St. Luke's Medical Center Global City or a hospital chosen at CISM discretion will be for the account of the student.

I certify that all information given on the Medical Form is complete and correct. I acknowledge that it is my responsibility to inform the CISM Clinic of any changes in my child's health, physical condition, or medical requirements.

______________________________	______________________________	____________________
Signature of Father/Guardian (print name over signature)	Signature of Mother/Guardian (print name over signature)	Date

CHINESE INTERNATIONAL SCHOOL MANILA

Upper McKinley Rd., McKinley Hill
Fort Bonifacio 1634, Taguig City
+63(2) 798-0011 or +63(917) 798-0011
clinic@cismanila.org
www.cismanila.org

PHYSICAL EXAMINATION FORM

(to be completed by Licensed Physician)

Student's Name: LAST NAME / FIRST NAME / MIDDLE INITIAL	Date of Birth	Age	Gender: ❑ MALE ❑ FEMALE

SCREENING and TESTING

Height	Weight	Blood Pressure	Blood Type	Pulse Rate	Vision: R_____ L_____ Both _____

PHYSICAL EXAMINATION

Please review the following areas:	Normal	Abnormal	Finding/Comments
Head, Eyes, Ears, Nose, Throat			
Mouth/Dental			
Respiratory			
Cardiovascular			
Gastrointestinal			
Hernia			
Genitourinary			
Musculoskeletal			
Metabolic/Endocrine			
Neuropsychiatric			
Skin			

Does the child have a diagnosed health condition which may require EMERGENCY ACTION while he/she is at school? (e.g. seizure, allergy, asthma, bleeding problem, diabetes, heart problem, etc.) ☐ Yes ☐ No
If yes, please describe and include instructions regarding plan of care.

____

____

REVIEW OF RECORDS I have reviewed the ff records:

❑ immunization records (all grade levels)

❑ TB screening form (new students, grade 6, grade 9 and those who have been to countries listed on the form)

SUMMARY OF FINDINGS

______________________________ has had a complete physical examination and has:
(Student's Name)

❑ no conditions identified that may affect full school participation

❑ conditions identified that may affect full school participation (specify conditions below):

____ Allergy: ❑food: ______________ ❑medication: ______________ ❑other: ______________

Type of allergic reaction: ❑anaphylaxis ❑local reaction

Response required: ❑Epi-pen ❑other: ______________________

____ Restricted Physical Activity: ______________________________________

____ Medication that must be given and/or available at school

____ Special Diet: ______________________________________

Physician's Printed Name	License No.	Date
Address	Phone No.	Signature