DON BOSCO TECHNICAL INSTITUTE
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STUDENT HEALTH RECORD

Name:_________________________________ Date of Birth:_____________Grade & Section_________________
Address:____Home Tel. No.______________
Mother: ___________________________________ Cell No. ___________________ Office No. ___________________
Father: ___________________________________ Cell No. ___________________ Office No. __________________
Guardian: _________________________________ Cell No. ___________________ Office No. __________________

MEDICAL HISTORY

Existing medical condition/ s:____
Please list all medications currently taking: ____

IMMUNIZATION

VACCINE	DOSE	DATE OR AGE GIVEN	VACCINE	DOSE	DATE OR AGE GIVEN
BCG	Dose 1		Pneumococcal (PCV)	Dose 1	
Hepatitis B	Dose 1			Dose 2	
	Dose 2			Dose 3	
	Dose 3			Dose 4	
	Dose 4		Rotavirus	Dose 1	
				Dose 2	
Diphtheria, Pertussis, Tetanus	Dose 1			Dose 3	
	Dose 2		Measles	Dose 1	
	Dose 3		Measles, mumps, rubella (MMR)	Dose 1	
	Booster 1			Dose 2	
	Booster 2		Chickenpox (Varicella)	Dose 1	
Polio	Dose 1			Dose 2	
	Dose 2		Hepatitis A	Dose 1	
	Dose 3			Dose 2	
	Booster 1		Typhoid	Dose 1	
	Booster 2			Dose 2	
H. influenza type B (Hib)	Dose 1		Meningococcal	Dose 1	
	Dose 2			Dose 2	
	Dose 3		Seasonal Flu (influenza)		
	Dose 4		Others		

PHYSICAL EXAMINATION

(To be completed by Licensed Physician)

Height: Weight: BMI: Temp:		
BP / Pulse RR Vision R 20/ L 20/ Corrected ❑ Y ❑ N		
	NORMAL	ABNORMAL FINDINGS
Appearance		
HEENT		
Neck		
Chest / Lungs		
Heart		
Abdomen		
Genitalia		
Extremities		
Skin/hair/nails		

Does the child have a diagnosed health condition which may require EMERGENCY ACTION while he 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.
____
____

I have examined the above-named student. He has:

- ☐ No conditions identified that may affect full school participation
- ☐ Conditions identified that may affect full school participation (specify conditions below):
  ____

Recommendations:
____
____

Name of Physician & signature:______________________________ Date:______________________________
License No.____
Clinic Address____ Phone No.________________________