REPUBLIC OF THE PHILIPPINES
JOSE RIZAL MEMORIAL STATE UNIVERSITY
The Premier University in Zamboanga del Norte
GOV. GUADING ADAZA ST., STA. CRUZ, DAPITAN CITY, ZAMBOANGA DEL NORTE

UNIVERSITY CLINIC

JRMSU CLI- 001 STUDENT'S HEALTH RECORD

School ID No. _____ **Grade / Course & Year:** _____

Name _____
(LAST) (FIRST) (MIDDLE)

Sex **Gender Identity**
Female ☐ L ☐ B ☐
Male ☐ G ☐ T ☐

Birthdate _____/_____/_____
(MONTH) (DAY) (YEAR)

Address: _____

Contact Number: _____

Parent's Name _____ (MOTHER/LEGAL GUARDIAN) _____ (FATHER/LEGAL GUARDIAN)

Contact Numbers _____ (MOTHER/LEGAL GUARDIAN) _____ (FATHER/LEGAL GUARDIAN)

Are you having allergies? Pls. specify:_____
_____

MEDICAL HISTORY

Allergy ☐	Chronic Cough ☐	Vertigo ☐	Skin Problems ☐
Asthma ☐	Vision Problems ☐	Hypertension ☐	Anaemia ☐
Hyperventilation ☐	Hearing Problems ☐	Appendectomy ☐	Migraine headache ☐
Epilepsy/Seizures ☐	Heart Disease ☐	Fractured bones ☐	Diabetes ☐

Are you receiving treatment for these conditions? Yes ☐ No ☐

PHYSICIAN'S EXAMINATION CODE: N – Normal; A – Abnormal; C – Corrected; R – Receiving Care

Date	Grade/Year Level	Height	Weight	BMI	Blood Pressure	Vision		Hearing		Eyes	Ears	Nose	Throat	Teeth	Heart	Lungs	Abdomen	Skin problem	Scoliosis	Upper extremities	Lower Extremities	Nutrition	Chickenpox (Varicella) Immunity Secondary to Disease (Date) MM/DD/YY	Reviewed Immunization Record (Check if YES)	Completed TB Screening (Check if YES) See results below	Provider's Signature	Provider's Stamp or Printed Name
						R	L	R	L																		
/ /																							/ /				
/ /																							/ /				
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/ /																							/ /				

CHEST X-RAY

Test	Date	Result	Physician/ Laboratory
	/ /		

HBsAG

Test	Date	Results	Physician/Laboratory
	/ /		

URINALYSIS

Test	Date	Results	Physician/Laboratory
	/ /		

BLOOD TYPE

Test	Date	Results	Physician/Laboratory
	/ /		

CBC

Test	Date	Results	Physician/Laboratory
	/ /		

ECG

Test	Date	Results	Physician/Laboratory
	/ /		

PREGNANCY TEST

Test	Date	Results	Physician/Laboratory
	/ /		

SGPT

Test	Date	Result	Physician/ Laboratory
	/ /		

VISUAL ACUITY

Test	Date	Results	Physician/Laboratory
	/ /		

AUDIOMETRY

Test	Date	Results	Physician/Laboratory
	/ /		

PSYCHOLOGICAL TEST

Test	Date	Results	Physician/Laboratory
	/ /		

STOOL EXAMINATION

Test	Date	Results	Physician/Laboratory
	/ /		

DRUG TEST

Test	Date	Results	Physician/Laboratory
	/ /		

DENTAL EXAMINATION

Test	Date	Results	Physician/Laboratory
	/ /		

LMP: _____
Note: for clinic use only

Health History Comments: Include referrals & reports

PERSON WITH DISABILITY/ IMPAIRMENT
Yes ☐ No ☐
If Yes, specify_____

Date of confinement	Illness	Diagnosis	Medications taken	Referrals/ Follow-up	Health Status

Pursuant to Data Privacy Act of 2012, I hereby give my consent that my personal information on health assessment could be utilized by the University for academic, administrative, and research purposes.

_____ _____
(Signature over printed Name) (Date Signed)

Treatment Record

Date	Symptoms/Complaints	First Aid Treatment/ Non-Pharmacologic Management	Medication Administered (Drug, Dose, Frequency)	Name & Signature of Clinic Nurse