

# The Beacon Academy

A Private International School

2332 PCPD Building Don Chino Roces Ext. Taguig City  
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Website: http://www.beaconacademy.ph

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## MEDICAL FORM

Student's Name \_\_\_\_\_ Nickname \_\_\_\_\_

Address \_\_\_\_\_

Home Telephone # \_\_\_\_\_

Birthday \_\_\_\_\_ Birthplace \_\_\_\_\_

Nationality \_\_\_\_\_ Sex \_\_\_\_\_

Child's Blood Type \_\_\_\_\_

Name of Father \_\_\_\_\_

Business Address \_\_\_\_\_

Phone \_\_\_\_\_ Mobile No. \_\_\_\_\_

Name of Mother \_\_\_\_\_

Business Address \_\_\_\_\_

Phone \_\_\_\_\_ Mobile No. \_\_\_\_\_

If unable to contact parents call \_\_\_\_\_

Phone \_\_\_\_\_

Child's Pediatrician \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Mobile No. \_\_\_\_\_

Child's Dentist \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Mobile No. \_\_\_\_\_

### Health History

Please indicate if your child has any problems with the following and provide further details:

Vision \_\_\_\_\_

Hearing \_\_\_\_\_

Speech and Language \_\_\_\_\_

Asthma \_\_\_\_\_

Others \_\_\_\_\_

Please indicate if your child has any allergies:

Food \_\_\_\_\_

Medicines \_\_\_\_\_

Others \_\_\_\_\_

Please check if your child has past history of the following diseases:

Asthma

Chicken pox

Chronic Ear Infections or Otitis Media

Febrile Convulsions

Hepatitis A

Hepatitis B

Measles

Meningitis

Mumps

Primary Complex

Urinary Tract Infections

Whooping Cough

Others, pls. specify \_\_\_\_\_

Please indicate any specific medical condition of which the school should be aware \_\_\_\_\_

Any recent health problems /concerns? \_\_\_\_\_

### Immunization History

	1 <sup>st</sup>	2 <sup>nd</sup>	3 <sup>rd</sup>	Boosters		
BCG						
DPT						
DPT Booster						
OPV						
OPV Booster						
Hepatitis B						
HiB						
Measles						
Mumps						
Rubella						
MMR Booster						
Hepatitis A						
Varicella						
Typhoid						
Cholera						
Others						

Medications taken on a regular basis \_\_\_\_\_

Your child's common medicine for:

Colds \_\_\_\_\_

Fever \_\_\_\_\_

Cough \_\_\_\_\_

Allergy \_\_\_\_\_

Headache \_\_\_\_\_

**Please tick the box below:**

I do/do not authorize the nurse:

To render first-aid to my child

To administer medicine to my child in cases of emergency.

\_\_\_\_\_  
Parent's Name & Signature