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 CLIN 001 STUDENT'S HEALTH RECORD

School ID No. ____________________ **COURSE&YR:** ________________________________

Name ____ **Female** ☐ **Male** ☐
(LAST) (FIRST) (MIDDLE)

SCHOOL YEAR FIRST REGISTERED
Junior High (MM/DD/YY) ___/____/____
Senior High (MM/DD/YY) ___/____/____
College (MM/DD/YY) ___/____/____
Post-Graduate (MM/DD/YY) ___/____/____

Birthdate _______/_____/_______ Address: ________________
(MONTH) (DAY) (YEAR)

Contact Number: ____________________
Parent's Name ______________________ ______________________
(MOTHER/LEGAL GUARDIAN) (FATHER/LEGAL GUARDIAN)

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

ALLERGIES: ________________________
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____

MEDICAL HISTORY				
Allergy ☐	Chronic Cough ☐	Skin Problems ☐	Leukaemia ☐	Are you receiving treatment for these conditions? Yes ☐ No ☐
Asthma ☐	Vision Problems ☐	Hypertension ☐	Anaemia ☐	
Hyperventilation ☐	Hearing Problems ☐	Appendectomy ☐	Migraine headache ☐	
Epilepsy/Seizures ☐	Heart Disease ☐	Fractured bones ☐	Diabetes ☐	

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	Nervous System	Skin	Scoliosis	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																		
/ /																							/ /				
/ /																							/ /				
/ /																							/ /				
/ /																							/ /				

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

PROJECT

Health History Comments: Include referrals & reports

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