

FAITH ACADEMY MINDANAO

PARENTS, please fill out this sheet as completely as possible. This information will be treated as confidential and will assist the Health Services.

Student Passport Name: _____ Sex: _____ Grade (in which enrolling): _____
 Name Used: _____ Student's Birth Date: _____
 Student's Birthplace: _____
 Father's Name: _____ Mother's Name: _____
 Father's Birthplace: _____ Mother's Birthplace: _____
 Home Address: _____ Home Phone: _____
 Cell Phone(s): Father: _____ Mother: _____
 Mission or Business _____ Phone: _____
 Mission or Business Address: _____

IMMUNIZATION HISTORY

List dates of immunizations and tests which your child has received. This form will not be accepted without this information. When writing dates, please use the following order: MONTH, DAY, YEAR.

***DPT, Polio, and MMR are required for entrance into school**

Diphtheria-Pertusses-Tetanus (DPT)					
Diphtheria-Tetanus (dT)					
Tetanus Toxoid					
Polio (O=oral I=injection)					
H I B					
Measles					
M M R					
Typhoid (O=oral I=injection)					
B C G					
Hepatitis B					
Hepatitis A					
Chicken Pox					
Rabies					
Japenese Encephalitis					
Influenza					
OTHERS					

Tuberculin Skin Test Date: _____ Result: _____
 Date: _____ Result: _____
 Chest X-Ray Date: _____ Result: _____
 Date: _____ Result: _____
 TB Treatment Dates: _____ Medications: _____

MEDICAL HISTORY

	Family Health History
Father	
Mother	
Siblings	

*******Please complete important health information on reverse side....**

Give approximate dates of any of the following diseases that your child has experienced:

Ameobic Dysentery	Malaria	Typhoid Fever
Bacillary Dysentery	Measles	Diphtheria
Chicken pox	Meningitis	Diabetes
Cholera	Mononucleosis	Bleeding Disorders
Dengue Fever	Mumps	Other
Pneumonia	Hepatitis	Other
German Measles	Rheumatic Fever	Asthma
Epilepsy	Scarlet Fever	
Surgeries	Tuberculosis	Learning Disabilities

Is your child currently under medical care for any of the above: ___No ___Yes If yes, explain. Include name of physician)

Is your child taking any medications on a regular basis? ___ No ___ Yes If yes, what? _____

Does your child have any allergies? ___ No ___ Yes, to medications ___Yes, others If Yes, please list allergies and reactions: _____

Has your child ever had a head injury requiring medical or surgical treatment? ___ No ___ Yes If yes, give date, details, and treatment _____

Is there anything else we need to know about your child that may affect them while at school?
