Form H-1 (New Students)

MARIA MONTESSORI FOUNDATION

Caimito Drive, Ayala Alabang Village, City of Muntinlupa

(To be filled up by Family Physician)

HEALTH EXAMINATION RECORD

Name _____ Sex _____ Level [ ] Casa [ ] GS2 [ ] GS 1 [ ] HS

Address _____ Tel. No. _____

Birthdate _____ Height _____ Weight _____ PR _____ BP _____

DISEASE HISTORY (Check which the child has had)

____	Appendicitis	____	Frequent Indigestion	____	Pneumonia
____	Asthma	____	Frequent Nose Bleeding	____	Scoliosis
____	Bronchitis	____	Frequent Sore Throats	____	Seizures/Convulsions
____	Chicken pox	____	Headaches	____	Typhoid/Dengue Problem
____	Common Colds	____	Heart Trouble	____	Tonsilitis
____	Diabetes	____	Measles	____	Others _____
____	Diptheria	____	Mumps		_____
____	Earaches	____	Pains in legs or joints		_____

Check if the child has had any of these. If so, please describe.
_____ surgical operation _____ accident _____ injuries _____ allergies

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Special Problems	No	Yes	If Yes, please describe below
Speech Problem	___	___	_____
Vision Problem	___	___	_____
Wears glasses	___	___	_____
Hearing Problem	___	___	_____
Describe Others	_____		

Vaccination Record

CTAB	____	Polio	____
DPT	____	Tuberculin Test	____
Hepa B	____	Others	____
Measles	____		
Mumps	____		

Has the child been hospitalized? No ( ) Yes ( ) If yes, why? _____
When and how long? _____
Does the child take any medicine on a regular basis? No ( ) Yes ( ) If yes, what? _____
How often? _____ Doctor's prescription _____
Has the child had a Chest X-ray? No ( ) Yes ( ) If yes, date of last X-ray _____
Findings: _____
Tuberculosis in family: No ( ) Yes ( ) If yes, who? _____

PHYSICAL ACTIVITIES

	FIT	NOT FIT	STATE REASONS/AILMENTS FOR EXCUSE TO NOT PARTICIPATE IN SUCH ACTIVITIES ON A MORE PERMANENT BASIS
a. Regular Swimming Classes	_____	_____	_____
b. Other Sports Activities (Please Specify)	_____	_____	_____

Other Health Problems and Special Concerns: _____
_____
Is the child covered by any medical or accident insurance? No ( ) Yes ( ) If yes, please identify policy and coverage

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Family Physician _____ License No. _____
(Please print name under signature)

Contact Address _____ Phone No. _____
Date of last medical consultation? _____ Purpose _____

_____
Parent's printed name under signature

Date filled up _____
Date received at MMF _____
Receiving Personnel _____