ATENEO DE MANILA UNIVERSITY

JUNIOR HIGH SCHOOL HEALTH SERVICES

AJHS STUDENT'S HEALTH INFORMATION SY 2018- 2019

To be accurately completed by Parents/Guardians and to be submitted to the AJHS Health Services Office.
All information contained within will be kept confidential.

STUDENT INFORMATION

Name:

_____
(Last) (First) (Middle)

ID Number: _____ **Cluster/ Grade / Sec.:** _____ **Date of Birth:** _____/_____/_____ **Age:** ____

Home Address:

_____ **Home Number:**

_____

_____ **Mobile Number:**

_____

CONTACT INFORMATION

	MOTHER	FATHER	EMERGENCY CONTACT (If parents cannot be reached)		
Name			**Name:**	1.	2.
Address (if different from above)			**Contact Number:**		
Home Number			**PHYSICIAN**		**DENTIST**
Work Number			**Name:**		**Name:**
Cellphone Number			**Contact Number:**		**Contact Number:**
Email Address					
PREFERRED PARENT to inform in Case of Emergency (Please check box)					

MEDICAL/HEALTH HISTORY

MEDICAL CONDITION	NO	YES	If YES, Explain. (Attach additional sheet if necessary)
1. Allergies (type)			
2. Asthma			
3. Other Respiratory Illnesses			
4. Cardiac Diseases			
5. Hypertension			
6. Diabetes Mellitus			
7. Seizure Disorders/Epilepsy			
8. Other Neurological Conditions			
9. Musculoskeletal Disorders - Fine/gross motor deficit			
10. Vision Disorders			
11. Hearing Disorders			
12. Speech/Language Disorders			
13. Emotional/Behavior Disorders			
14. Other Illnesses			
Regular prescription or over-the-counter medication			
Surgical Operations			
Accidents (sports/non-sports related injury)			

CONSENT TO TREATMENT

I hereby grant permission to the physicians, dentist and staff of the Ateneo de Manila Junior High School Health Services to render my son any medical and/or dental treatment that they deem necessary as part of first aid treatment especially during but not limited to emergency cases. I understand that the Ateneo de Manila Junior High School Health Services will make all possible effort to inform me in the event of such treatment in an emergency.

By signing below, I attest that the information contained herein is correct to the best of my knowledge and that I have read the CONSENT TO TREATMENT provision above, fully understand their terms, and sign below freely and voluntarily without any inducement. I further acknowledge that I am the parent or legal guardian of the student.

Parent / Legal Guardian Name	**Parent / Legal Guardian SIGNATURE**
Name of Student	**Date: MM / DD / YYYY**

PHYSICAL EXAMINATION (To be completed by Physician)

Student's Name: _____ Age**/Sex:** _____

(Last) (First) (Midd

Height: _____cm **Pulse rate:** _____/min **RR:** _____/min

Weight: _____kg **BP:** _____/_____ **Temp.** _____◦C

VISION	WITHOUT GLASSES	WITH GLASSES
Right Eye		
Left Eye		
Both Eyes		

	NORMAL	ABNORMAL FINDINGS (Attach additional sheet if necessary)
1. General Appearance		
2. Head		
3. Eyes – General		
4. Ears – General		
5. Nose		
6. Mouth and Throat		
7. Neck/Thyroid		
8. Chest/Breast		
9. Respiratory		
10. Cardiovascular		
11. Gastrointestinal		
12. Genitourinary		
13. Skin		
14. Lymphatics		
15. Peripheral Pulses		
16. Musculoskeletal		
17. Neurologic		

Other problems/conditions that may affect his/her educational performance:

Speech/Language
Fine/Gross Motor Deficit
Behavioral
Emotional/Social
Metabolic
Others: _____

* Consider doing additional test for abnormal findings on history or physical exam (e.g., ECG, echocardiogram for abnormal cardiac findings, GU exam, cognitive evaluation / baseline neuropsychiatric testing or x-rays). Please indicate results if done.

IMMUNIZATION HISTORY: ** Kindly indicate DATE(S) given. May attach immunization record on separate sheet.

Tdap: _____

Influenza (last given): _____/ _____

Pneumococcal: _____/ _____

MMR: _____/ _____

Chickenpox: _____/ _____

Hepatitis B: _____/ _____/ _____

**** Recommended but not required.**

ASSESSMENT OF EXAMINING PHYSICIAN

I certify that the above examination was done with the following conclusion(s):

☐ Cleared without limitations.
Cleared with precautions.
Cleared after completing evaluation/rehabilitation for _____
Not cleared for _____
Reason: _____

Recommendations: _____
_____
_____

Name and Signature: _____ **Contact Number:** _____

License Number: _____ **Address:** _____

Date: _____ _____

ATENEO DE MANILA UNIVERSITY

JUNIOR HIGH SCHOOL DENTAL HEALTH SERVICES

DENTAL EXAMINATION RECORD

Name of Student: _____ **Date:** _____

(Last) (First) (Middle)

Cluster/ Grade/Sec: _____

DENTAL HEALTH STATUS:

55	**54**	**53**	**52**	**51**	**61**	**62**	**63**	**64**	**65**
85	**84**	**83**	**82**	**81**	**71**	**72**	**73**	**74**	**75**

18	**17**	**16**	**15**	**14**	**13**	**12**	**11**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**
48	**47**	**46**	**45**	**44**	**43**	**42**	**41**	**31**	**32**	**33**	**34**	**35**	**36**	**37**	**38**

INITIAL SOFT TISSUE EXAM				
□ Lips	□ Floor of Mouth	□ Palate	□ Tongue	□ Neck & Nodes

INITIAL PERIODONTAL EXAM			
GINGIVAL INFLAMATION:	□ Slight	□ Moderate	□ Severe
SOFT PLAQUE BUILDUP:	□ Slight	□ Moderate	□ Heavy
HARD CALC BUILDUP:	□ Light	□ Moderate	□ Heavy
STAINS:	□ Light	□ Moderate	□ Heavy
HOME CARE EFFECTIVENESS:	□ Good	□ Fair	□ Poor
PERIODONTAL CONDITION:	□ Good	□ Fair	□ Poor
PERIODONTAL DIAGNOSIS:	□ Normal	□ Gingivitis	
PERIODONTITIS:	□ Early	□ Moderate	□ Advanced
MUCOGINGIVAL DEFECTS:			

CLINICAL DATA				
OCCLUSION:	□ Class 1	□ Class II	□ Class III	
T.M.J. EXAM:	□ Pain	□ Popping	□ Deviation	□ Tooth Wear

ORAL HEALTH CONDITION				
Date of Examination				
Age last birthday				
Presence of Debris	Y	N	Y	N
Inflammation of Gingiva	Y	N	Y	N
Presence of Calculus	Y	N	Y	N
Under Orthodontic Treatment	Y	N	Y	N

Dentofacial Anomaly, Neoplasm, Others, specify:

_____

_____

_____

TOOTH COUNT	**T**	**P**	**T**	**P**

Number of Teeth Present				
Number of Caries Free Teeth				
Number of Decayed Teeth				
Number of Missing Teeth				
Number of Filled Teeth				
Total df &DMF Teeth				

DENTAL/ORAL EXAMINATION REVEALED THE FOLLOWING CONDITIONS AND RECOMMENDATIONS.

_____ Caries Free
_____ Poor Oral Hygiene (Materia Alba, Calculus, Stain)
_____ Indicated for Restoration/Filling
_____ Indicated for Extraction
_____ Gingival inflammation
_____ Needs Oral Prophylaxis
_____ Needs Prosthesis (Denture)
_____ For Endodontic Treatment
_____ For Orthodontic Consultation
_____ For Pits and Fissures Sealant Application
_____ Others
_____ No Dental Treatment Needed at Present

TO THE EXAMINING DENTIST

Please accomplish the treatment needed and provide other dental history of the patient.
Kindly sign and send back this form for inspection to the Ateneo de Manila High School Dental Health Services.

Dental Treatment Given: _____
_____
_____

_____
Dentist's Signature over Printed Name
License no._____