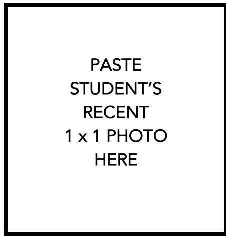
ATENEO DE MANILA UNIVERSITY

SENIOR HIGH SCHOOL HEALTH SERVICES

ASHS M-01
Rev. 2018



STUDENT'S HEALTH INFORMATION | SY ___________

To be accurately completed by Parents/Guardians. All information contained within will be kept confidential, following the university's data privacy policy.

STUDENT INFORMATION

Name: ____

(Last) (Given Name) (Middle)

ID Number: _________________ Year & Sec.: _____________ Date of Birth: _____/_____/_____ Sex: ________Age: ________

Home Address:

____ Home Number: ____________________

____ Mobile Number: ____________________

CONTACT INFORMATION

	MOTHER	FATHER	EMERGENCY CONTACT/S If parents cannot be reached	
NAME			NAME	NAME
ADDRESS (if different from above)			CONTACT NO	CONTACT NO
HOME NO			MEDICAL CARE PROVIDER	DENTAL CARE PROVIDER
WORK NO			NAME	NAME
MOBILE NO				
EMAIL			CONTACT NO	CONTACT NO

MEDICAL/HEALTH HISTORY

MEDICAL CONDITION	NO	YES	If YES, please 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 OTC medication			
Surgical Operation/s			
Accidents (sports/non-sports related injury)			

CONSENT TO TREATMENT

I hereby grant permission to the physicians, dentist, and staff of the Ateneo de Manila High School Health Services to render my son/daughter 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 Senior 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.

______________________________	______________________________
PRINTED NAME OF PARENT / LEGAL GUARDIAN	**SIGNATURE OF PARENT / LEGAL GUARDIAN**
______________________________	______________________________
NAME OF STUDENT	**DATE (MM / DD / YYYY)**

PHYSICAL EXAMINATION (*To be completed by Physician*)

STUDENT'S NAME: ____ **AGE/SEX:** ____________
(LAST) (GIVEN NAME) (MIDDLE)

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: (must have 2 doses) __________ /_________
Chickenpox: (must have 2 doses) _______ /_____
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 & SIGNATURE: ______________________________ CONTACT NO: ______________________________

LICENSE NUMBER: ____________________ ADDRESS: ______________________________________

DATE: ______________________________ ______________________________________

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ATENEO DE MANILA UNIVERSITY

DENTAL HEALTH SERVICES

DENTAL EXAMINATION RECORD

STUDENT'S NAME: ______________________________ GR/SEC: __________ DATE: ____________
(Last) (Given) (Middle)

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

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				

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

INITIAL PERIODONTAL EXAM			
GINGIVAL INFLAMMATION:	☐ 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

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.**