The Discovery Academy
of Innovation

2F KDC Plaza Building,
2212 Chino Roces Ave.,
Makati City, 1230 Philippines
info@sparklelab.ph

Health Assessment Form

S.Y 2021-2022

This form is to be completed and certified by a
Licensed Physician and submitted as a hard copy

FOR OFFICE USE ONLY	
Form Details	☐ Completed
Reviewed by	
Date Reviewed	
Admission #	

Date Submitted
(MM/DD/YYYY)

Section A
Basic Information

Student's Name *Last Name* / *First Name* / *Middle Name*			Gender
Date of Birth *(MM/DD/YYYY)*	Height (cm)	Weight (kg)	Blood Pressure

Section B
Family Information

Father or Guardian #1's Name *Last Name* / *First Name* / *Middle Name*			Relationship to Applicant
Home Address		Company Name	
Home Phone Number	Mobile Phone Number	Direct Office Line	Office Phone Number

Mother or Guardian #2's Name *Last Name* / *First Name* / *Middle Name*			Relationship to Applicant
Home Address		Company Name	
Home Phone Number	Mobile Phone Number	Direct Office Line	Office Phone Number

Privacy Statement: All personal information will be kept securely and remain confidential. Any changes to this form must be signed and dated by a parent or legal guardian

Section C
Emergency Contact

Emergency contact in case Parents cannot Be reached Please Notify the Admissions Office of any changes in phone numbers or contact persons.		Name	Phone Number	Mobile Number	Relationship to student
	Primary Contact				
	Secondary Contact				
	Local Doctor or Health Contact Provider				

Section D:
Health Area

Is there evidence of concern for any of the areas listed below?
Indicate the results of your examination by checking the appropriate space.

Vision	☐ Yes	☐ No	☐ Not Evaluated
Auditory	☐ Yes	☐ No	☐ Not Evaluated
Development	☐ Yes	☐ No	☐ Not Evaluated
Speech/Language	☐ Yes	☐ No	☐ Not Evaluated
Nutrition	☐ Yes	☐ No	☐ Not Evaluated
Emotional/Social	☐ Yes	☐ No	☐ Not Evaluated
Behavior	☐ Yes	☐ No	☐ Not Evaluated
Physical Impairment/Illness	☐ Yes	☐ No	☐ Not Evaluated

Details of any findings/ and other comments

Section D:
Medication

(Prescription or over the counter/ self-medication)

Note: If the medication needs to be taken during school hours, a letter from the Medical Doctor must be kept on file at the Clinic. The medication needs to be dispensed by the school doctor or nurse

Is the student on long-term medication? ☐ Yes ☐ No

If yes, kindly state the condition being treated _____

Brand name _____

Generic Chemical Description _____

Renewal Prescription _____

Medication Instructions (With/ Before/ After meals, etc.

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Is the child able to participate in physical education activities? (Yes, No) ☐ Yes ☐ No	Any recent health problems/ concerns? ☐ Yes ☐ No
Any recent health problems/ concerns?	Comments
Other relevant information	

Section E: Parent/s Declaration

Permission is given for emergency measures in case of accidents or severe illness with the understanding that I will be notified as soon as possible. I certify that all the information given is complete and correct, It is my responsibility to update the DAI clinic for any physical changes or medical needs.

☐ **Yes** I give my consent to DAI to process my personal information and sensitive information as detailed in the DAI DATA Privacy Policy.

☐ **No** I do NOT give my consent to DAI to process my personal information and sensitive information as detailed in the DAI DATA Privacy Policy.

Parent / Guardian's Name

Parent / Guardian's Signature

Date
(MM/DD/YYYY)

Section F: Medical History

Chronic Conditions & Recurring Medical Problems

Drug Reactions	☐ Yes ☐ No	Year	Emotional / behavior counseling	☐ Yes ☐ No	Year
Allergic reactions	☐ Yes ☐ No	Year	Wear braces or has "caps"/ artificial teeth	☐ Yes ☐ No	Year
Asthma or other lung/ respiratory disorder	☐ Yes ☐ No	Year	Glasses	☐ Yes ☐ No	Year
Enuresis (Bed wetting)	☐ Yes ☐ No	Year	Physical Limitations	☐ Yes ☐ No	Year
Tuberculosis	☐ Yes ☐ No	Year	Special Diet	☐ Yes ☐ No	Year
Endocrinal disorder: Diabetes type I, Diabetes type II, or Thyroid	☐ Yes ☐ No	Year	Hospitalization	☐ Yes ☐ No	Year
Epilepsy	☐ Yes ☐ No	Year	Ear / nose/ throat disorder	☐ Yes ☐ No	Year
Ear/ nose/ throat disorder	☐ Yes ☐ No	Year	ADD/ADHD	☐ Yes ☐ No	Year
Emotional / behavior counseling	☐ Yes ☐ No	Year	Glasses	☐ Yes ☐ No	Year
Wear braces or has "caps" or artificial teeth	☐ Yes ☐ No	Year	Physical Limitations	☐ Yes ☐ No	Year
Hospitalization	☐ Yes ☐ No	Year	Special Diet	☐ Yes ☐ No	Year

Details of any findings / and other comments:

Section G:
Immunization History

VACCINE	DATE EACH DOSE WAS GIVEN (MM/DD/YYYY)			
Tuberculosis BCG				
Hepatitis B				
Diphtheria, Pertussis, and Tetanus				
DPT Booster				
Polio Vaccine OPV/IPV				
OPV/IPV Booster				
Meningitis				
Measles				
Measles, Mumps, and Rubella (MMR)				
Pneumonia Pneumococcal (PCV)				
Rotavirus				
Chicken Pox (Varicella)				
Hepatitis A				
Typhoid				
Meningococcal				
Influenza				
Japanese Encephalitis				

Others (Specify):

Section H:
Physician's Details

Physician's Printed name	**Signature and Title**
License Number	
Office Phone Number	**Date** *(MM/DD/YYYY)*

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