

UNIVERSITY OF THE PHILIPPINES HEALTH SERVICE

J.P. Laurel Avenue, Diliman, Quezon City

HEALTH DECLARATION FORM

For School Year 2020-2021, in lieu of the usual Physical Examination and Chest X-ray, incoming students are required to complete the Health Declaration Form for admission. This form will be part of your medical records as a student and will be treated with utmost confidentiality. Please type or write in black or blue ink only.

2"x2" or passport-size
colored ID photo
taken within the last
3 months

- Allergy to: _____
- No known allergies

UP Student No.: _____

Personal Information

Last Name	First Name	Middle Name	Sex at Birth
Date of Birth: _____ (mm/dd/yyyy)	Birthplace: _____	Age: _____	
Contact No.: _____	Email Address: _____		
UPD College/ School of Registration: _____			
Home Address: _____			
Name of Parent/ Guardian/ Spouse: _____			
Address: _____		Contact No.: _____	

Medical History

Have you ever had or do you have any of the following? Check **EACH** item **YES or NO**. If yes, give details.

	Yes	No	Details		Yes	No	Details
Accident/ Injuries				Joint Pain/ Arthritis			
Anemia/Blood Disorder				Kidney Disease			
Asthma				Malaria			
Autoimmune Disorder				Measles			
Cancer				Mental Problem/ Disorder			
Chickenpox/ Varicella				Mumps			
Convulsions				Neurologic Disorder			
COVID-19				Pertussis (Whooping Cough)			
Dengue Fever				Pneumonia			
Diabetes				Poliomyelitis			
Diphtheria				Rheumatic Fever			
Ear Disease/ Defect				Sexually Transmitted Infection			
Eye Disease/ Defect				Skin Disease			
Fracture				Surgery			
Heart Disease				Thyroid Disease			
Hepatitis (indicate type)				Tonsillitis			
Hernia				Tuberculosis/ Primary Complex			
High Blood Pressure				Typhoid			
Influenza A(H1N1)				Ulcer (Peptic)			

Personal/ Social History

Encircle your answer to the following questions:

- 1. Do you smoke cigarettes/ tobacco products? **YES** **NO**

- 2. Do you drink alcoholic beverages? **YES** **NO**

Answer the following questions briefly.

Describe any other important health-related information about you.
(for example: hospitalizations, health concerns requiring special treatment/ diet, etc.)

List all prescriptions and over-the-counter medications you are currently taking.

Do you have any immediate health concerns that you think may affect your studies? Please specify.

DECLARATION AND DATA SUBJECT CONSENT FORM

I certify that the above history is true to the best of my knowledge. I have fully disclosed all medical conditions that may affect my performance as a student of the University.

I also understand that the UP Health Service will not be liable to any untoward incident that may arise due to the deferral of the physical examination and Chest X-ray.

In compliance with the Data Privacy Act of 2012 and its Implementing Rules and Regulations, I voluntarily consent to the collection, processing, and storage of my personal and health information for the purpose/s of health assessment, treatment, and/ or research (following research ethics guidelines) for the improvement of healthcare services.

Name and Signature of Student

Note: Both student and guardian will affix their signatures, if the former is aged below 18 years old.