AQUINAS SCHOOL
183 F. Blumentritt St.
San Juan City

MEDICAL CERTIFICATE

NAME OF APPLICANT: ____
Last Name First Name Middle Name

SEX: ☐ MALE ☐ FEMALE AGE: ________

DATE OF BIRTH: _______________________ PLACE OF BIRTH: ______________________________
(MM/DD/YYY)

NAME OF FATHER: ____
Last Name First Name Middle Name

NAME OF MOTHER:____
Last Name First Name Middle Name

CURRENT ADDRES: ____

CONTACT NUMBERS: _____________________ ____________________ _____________________
Landline Cellular Phone 1 Cellular Phone 2

PERSON TO NOTIFY INC ASE OF EMERGECNY: ____

RELATIONSHIP: _____________________________ CONTACT NUMBER: _______________________

IMMUNIZATION HISTORY

(Please check appropriate boxes)

BCG	
DPT I	
DPT II	
DPT III	
BOOSTERS	
POV I	
OPV II	
OPV III	
BOOSTERS	
MEASLES	
MMR	
HEPATITIS B	
OTHERS:	

FINDINGS:
____
____
____

RECOMMENDATIONS:
____
____
____

I certify that the above mentioned student is physically fit for school.

____
Name of Attending Physician

____
License Number

____
Date

For any inquiries please contact the following:
Email: info_aquinas@yahoo.com; tel. Nos: 7245466 to 69; 7236756; Telefax: 7236755