



UNIVERSITY OF THE PHILIPPINES VISAYAS
HEALTH SERVICE UNIT
Miagao, Iloilo



HEALTH DECLARATION FORM

For the Academic Year 2020-2021, in lieu of the usual Physical Examination, Laboratory Tests 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.

- Allergy to: _____
- No known allergies.

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

UP Student No.: _____

PERSONAL INFORMATION

Last Name _____ First Name _____ Middle Name _____ Sex at Birth _____
 Date of Birth (MM/DD/YYYY): _____ Birthplace: _____ Age: _____
 UPV College/School of Registration: _____
 Tel. No.: (____) _____ Mobile No.: _____ Network: _____ Email Address: _____
 Home Address: _____

 Name of Parent/Guardian/Spouse: _____
 Address: _____

 Tel. No.: (____) _____ Mobile No.: _____ Network: _____

MEDICAL HISTORY CONDITIONS

Have you ever had or do you have any of the following? Check **EACH** item **YES** or **NO**. If YES, please 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			
Chicken Pox/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)/Hypracidity			

PERSONAL/SOCIAL HISTORY

Check the box YES or NO, for your answer to the following questions.

- | | | |
|--|------------------------------|-----------------------------|
| 1. Do you smoke cigarettes/tobacco products? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| 2. Do you drink alcoholic beverages? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

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 UPV Health Service Unit 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

Name and Signature of Guardian

NOTE: Both student and guardian will affix their signature if the former is aged below 18 years old.