School Health Services (School Clinic)
Policies ,Guidelines and Services

Second Edition

Chapter 1

School Health Office

I. Location

The school has a main medical clinic primarily responsible for safeguarding the health of students and school personnel. It is located in the Ground floor first building and opens during school hours from 7:30AM-4:00PM. The clinic is staffed by a full time nurse and an on-call doctor and dentist.

II. Clinic Personnel

Ruby Ann T. Aplaca,R.N, is a registered nurse .Completed her Bachelor's Degree in Nursing at University of Southern Philippines Foundation ,graduated in 2008 and took the board exam in the same year. A former staff nurse at Lapu-Lapu District Hospital and worked at the same time as a school nurse in Regent Pacific College. She has been a Company nurse in Monde Nissin for about one year. Because of the influence of the school she pursued a Diploma of Professional Education in Cebu Technological University and presently worked as a school nurse in Einstein School Cebu.

Dr. Rose May Dumaguin Camalongay, is a registered doctor. Graduated from University of Visayas, Gullas College of Medicine in 2005.She took Basic Course in Occupational Medicine conducted by the Philippine College of Occupational Medicine, Inc. that is duly accredited by the Department of Labor. She is currently worked as a school doctor in different ESL school in Lapu-Lapu City(CIA and QQ English,Einstein School for Kids-Cebu) concurrently she is also connected in Industrial company in MEPZ 2 as a Company Doctor (Knowles Electronic Company).She also run her own Medical Clinic in Lapu-Lapu City.

Dr. Ma. Jessica G. Campado, is a registered dentist ,completed her Doctor of Dental Medicine in Southwestern University.She also took Pediatric Dentistry in Philippine Children's Medical Center in Quezon Avenue,Quezon City. A member of Philippine Pediatric Dental Society, Inc. ,Philippine Dental Association , Inc. and Philippine Prosthodontic

Society. Presently worked as a school dentist in Asian College of Technology and a part time dentist in Einstein School for Kids-Cebu.

III. Goal

The ***school clinic*** provides medical and dental services. It promotes, develops and maintains the general wellbeing of all the members of the school. It disseminates vital health information through announcements.

IV. Objectives

- To assure adequate medical care to ill and injured
- To encourage personal health maintenance
- To protect the students against health hazards in the school environment
- To facilitate unfit students to resume classes without putting the risk of their own health and safety, and also other members of the school.

V. Functions

- Conduct annual medical and dental examination
- Attend to daily consultations with corresponding treatment and keeping accurate record
- Provide service to students who need to be transported to the hospital for further management
- Conduct ocular inspection in school premises to ensure cleanliness and safety

Chapter 2

School Health Services, Purpose and Programs

VI. SCHOOL HEALTH SERVICES

The School Health Services are established at the school site to promote the health of students through disease prevention, easy case finding, referral for intervention and remediation of specific health problems. The school health services are vitally necessary in order to provide first aid and triage for illness and injuries.

VII. PURPOSE OF SCHOOL HEALTH SERVICES

The primary purpose of the School Health Services Program is to promote physical and emotional health of students and staff thereby maximizing the educational process and work functionality.

VIII. PROGRAMS AND SERVICES

- Parents are obliged to answer and fill up completely and religiously the medical profile forms of the students**(Student Health Record)**
- Provide the school with your children special considerations like food allergies,medicine allergies,restriction to activities (with medical certificate),medical supervision and restriction and medical needs(hearing and vision difficulties)

CLINIC CONFINEMENT

- Any students who suffer from any sickness are accommodated at the clinic
- Basic first aid treatment and pharmacological management is given
- Parents, advisers are being notified

MEDICINES /SUPPLIES CONSUMPTION

- Students are given medicines /supplies based on availability and supply
- They are encouraged /obliged to bring first aid medications since supplies are also limited(paracetamol, neozep,mefenamic acid,Kremil-S etc.)
- Emergency drugs (asthma,heart medicines)

POLICY IN ISSUANCE OF MEDICINES

- Only starting dose is given to every patient
- Antibiotics are prescribed only by the physician
- Topical medication is applied on a daily basis
- Patient for IM (intramuscular injection) are entertained with referral note from attending physician
- Vaccination is available c/o Dr. Wilma Kou
- No medicine should be given to students with mild symptoms such as low grade fever, occasional cough except asthma.
- Patient who have asthma , Hypertension and other serious conditions should bring their own medicine at school
- Students with contagious illness should be isolated or be confined at home (chicken pox, measles, mumps etc.)

REFERRAL TO A HOSPITAL/ SPECIAL CLINICS

- Students with conditions that are aggravating are referred to the school Medical Doctor for further medical evaluation
- The consultation fee is shouldered by the school yet lab fees and medications are shouldered by the students /parents, (reimbursements from the school insurance is available)
- In case confined, a hospital of choice will be asked and granted. Hospitalization fees are shouldered by parents including PF(Professional Fee)
- In the hospital ,you may or may not choose the school doctor since the bill will be taken care of by you.
- As soon as parents are notified of their child's condition they are obliged to send somebody or come over to stay with their child at the hospital
- Students with communicable disease, are not allowed to report to school during the communicability period

IX. OTHER CLINIC POLICIES AND GUIDELINES

On issuance of excuse slip:

· Excuse slip is only given to students if they are seen and checked by the nurse on duty and assessed to have certain illness. They can be excused from class and will be allowed to go home.

On staying inside the clinic:

- Students are only allowed to stay and rest in the clinic if they are sick until their condition is stable and vital signs are normal.
- Students who are sick are not allowed to bring friends to stay with them.
- Only one person is allowed on each bed.
- Eating, while in bed, is strictly not allowed unless it is necessary.
- Visitors are not allowed to stay inside the clinic. They can visit for only 5 minutes.
- Students are not allowed to standby inside the clinic.

    - Nurses will not be responsible for "pulling" baby teeth. Do not send those students to the clinic.
    - If a student has a piercing that is infected (red, drainage, foul odor) they will be sent home.
    - Nurse will keep a logbook of all students visiting the clinic and disposition. The office will be informed when a student is being sent home.

Chapter 3

Roles of Parents, Teachers and Nurse

X. Parents -role

- Help in providing information about past, present medical history of medical problems
- Help in correction of defects and follow up of children
- Help in formation of good healthful living habits and behavior
- Participate and cooperate in physical and medical examination and immunization of children
- Through parent - teachers association parents are involved in planning , organizing and implementation of school health programs from normal health ,behavior, malnutrition/ communicable diseases.

<u>Prescribed medicine at school</u>

- When a medical doctor prescribed medication that must be administered during the school days, parents are responsible for
    - Bringing the attention of the school
    - Prescription medication must be in the original container and labeled, including the patient name, name of medication, dosage, and time to be given.
    - ensuring that the information is updated if it changes
    - supplying the medication and any 'consumables' necessary for its administration in a timely way
    - Collaborating with the school in working out arrangements for the supply and administration of the prescribed medication
      Only the school nurse, school doctor, or other staff member who is a medical professional will administer medications.

XI. School Teachers- role

- Daily inspection of personal hygiene and cleanliness

- Daily inspection of evidence of any deviation
- Referral of child having any problem to school health clinic
- Giving first aid and emergency care to children
- Imparting health education
- Help in control of communicable diseases

XII. School nurse- role

Health Promotion and Specific Protection

- Immunization of Children
- Helping school canteen personnel to plan a meal and snacks which is cheap, nutritious, hygeniecal and supplemental
- Health education to children, their parents and teachers
- Helping students, their parents and teachers who develop poitive attitude and health behaviour
- Examination of school environment

Early Diagnosis & Treatment

- Regular and periodical appraisal of children
- Notifying parents about health appraisal results
- Making referrals
- Follow-up
- Counseling of the students
- Provide first aid and emergency care for injury and illness

Prevention of Complications and Rehabilitation

- Helping in prevention of recurrence of acute conditions: by Eliminations of risk factors
- Prevention of complications by meeting special needs
- Prevention of adverse effects by counseling children

Nurse will keep a logbook of all students visiting the clinic and disposition. The office will be informed when a student is being sent home.

Chapter 4

HEALTH PROBLEMS AT SCHOOL

X. Acute Health Problems

Most illnesses and injuries that arise during school are minor (bumps, scrapes, headache) and can be cured. In many instances, the child can return to class. When the problem is more serious ,a parent will be called to come and take the child home. If the situation is extremely serious or life threatening, the child will be transported by an ambulance or school bus to the hospital's Emergency Room or to the nearest physician.

XI. Short-term Health Problems

Sometimes your child may have a health condition that does not last long but still interferes with her function at school. This kind of problem should be brought to the attention of the school nurse,the teacher or the school principal.

- Hearing loss r/t to an ear infection could require a change of temporary seat
- Some infections-ear infections,strep throat, bronchitis and sinusitis
- Readily visible problem,
- Injury or illness that requires mobilization

XII. Seeing the nurse

Students can go to the school's health office and speak with the nurse whenever they need to during the day.

Chapter 4

Incident Reporting

XVI. Policy Statement

The school is committed to enforce all health and safety guidelines to avoid such occurrences and expects employees to comply. However, accidents are sometimes inevitable. Our provision in this case is to ensure all accidents are reported timely so they can be investigated properly, and preventive measures can be reviewed and reinforced.

XVII. Accident and Incident Procedures

What is the difference between an accident and an incident?

An **accident** is an unfortunate event or occurrence that happens unexpectedly and unintentionally, typically resulting in an injury, for example tripping over and hurting your knee.

An i**ncident** is an event or occurrence that is related to another person, typically resulting in an injury, for example being pushed over and hurting your knee.

XVIII. Dealing with Accidents or Incidents to Children

We keep written records of all accidents, incidents or injuries to a child together with any first aid treatment given. Any event, however minor, is recorded by completion of an Accident/Incident Report" and the procedure is the same for both types of events as follows:

- An accident/ Incident Report is completed by the member of staff who witnessed the event.
- The IR/AC includes the child's name, the date of the incident or accident, the initials of the member of staff who completed the report and of countersign practitioner who also carries out the final checks on the report before filing it away

The following information is recorded on the Accident/Incident Report:

- Whether it is an accident or incident being report
- Full name of child

- Child's date or birth
- Date of accident or incident
- Time of accident or incident
- Name and signature of person who dealt with the accident or incident
- Description of accident or incident
- Description of care given
- Name of person who gave care (school Nurse or school Doctor)
- Description of Injury
- Position of the injury illustrated on the body map
- Witness signature (only if witnessed)
- Counter Signature

XIX. Dealing with Accidents that are not witnessed

The above procedure applies but with the following change:

If the accident, incident or injury has not been witnessed by a member of staff or other adult, then the member of staff dealing with the accident must gain an account of what happened from the child, and any other. If they are able to verbalize this or communicate in any other way. The member of staff must record the child's account of events on the Accident/Incident Report and clearly state that the accident was not witnessed

XX. Dealing with prior Accidents or Incidents to children

A "prior Accident or Incident "is an accident or incident that happened outside the setting/ school that has caused an injury or the seeking of medical advice. A prior Accident/Incident Report is completed by the parent or career each time they notify a member of staff about an accident or incident which has not happened in school.

The report is signed by the parent or carer and countersigned by a qualified practitioner. The following information is recorded on the Prior Accident/Incident Report:

- Whether it is an accident or incident being reported
- Full name of child
- Child's date of birth

- Date of accident or incident
- Time of accident or incident
- Description of accident or incident
- Description of care given
- Description of injury (if applicable)
- Position of the injury illustrated on the body map
- Signature of Nurse
- Counter signature (witness or MD)

XXI. Incident Portfolios

We keep an “Incident Portfolios” for recording all of the incidents and dangerous occurrences detailed below, including those incidents or accidents that happened outside the school. The Incident Portfolio is not for recording issues of concern involving a child. This is recorded in the child’s Personal File at the Prefect of Disciplines Office.

Chapter 5

Reimbursement Policy

Policies and Procedures of **CHARTER PING AN INSURANCE CORPORATION** under the Trade name **AXA Philippines.**

XXII. THINGS TO DO IN CASE OF ACCIDENTS/ILLNESS

Immediately report or submit a written formal loss advice to Claims Department (AXA Philippines)insurance company, within 3 days from of injury/illness indicating the following details:

1. Complete Assured's Name
2. Complete Claimant's/ Student's Name
3. Date of Accident/ Confinement
4. Brief Description of Accident/ Illness

Thereafter submit the following claims requirements as soon as possible:

XXIII. **BASIC REQUIREMENTS**

- Claim Statement Form (Forms will be provided by the **AXA Philippines** thru school clinic)
- Incident Report Narrating facts about the accident/injury sustained for minor injuries
- If accident is due to Vehicular traffic incident involving another party,please provide copy of POLICE REPORT
- Copy of Student ID

❖ IN ADDITION TO THE ABOVE BASIC DOCUMENTS THE FOLLOWING MUST BE SUBMITTED IN CASE OF:

A. FOR MEDICAL REIMBURSEMENT
    - Detailed Hospital Statement of Account (if hospitalized)
    - Original Official Receipts of Medicines, Laboratory, Consultation/ Professional Fees (Receipts must state type of medicines purchased)
    - Doctor's Prescription (Medicines, Laboratory, etc.)
    - Admitting History with Physical Examination if due Vehicular Traffic Incident

- Medical Certificate or Physician's Certificate (page 2 of claim statement form)

B. FOR DISABLEMENT
   - Clinical Summary /Record
   - Doctor's Certification of permanent disablement (If treatment fails patient must immediately notify PGAI of disablement up to 180 days)
   - if due to Vehicular Traffic Incident Pictures of proof of his/her disablement
   - Admitting History with Physical Examination

C. FOR FIRE ASSISTANCE
   - Certification from fire department
   - Joint affidavit of House Owner and Student concerned (for boarders)
   - Certification from Student Affairs Office Authority of student residency on record
   - Pictures of burn house
   - List of items/destroyed by fire

PLEASE TAKE NOTE OF THE WITHIN 30 DAYS NOTIFICATION REQUIREMENTS

IN CASE OF ACCIDENT/ CLAIM

NOTE: AXA Philippines its assigned Adjuster and agents reserves the rights to require additional documents or records relevant in the investigation/ examination of a claim whenever necessary.

Chapter 6

Equipments ,Machines and Medicines

XXIV. **The school clinic contain the following basic equipment, supplies and materials,**

A. EQUIPMENT

- ✔ Sphygmomanometer
- ✔ Stethoscope
- ✔ Weighing scale
- ✔ Examination bed
- ✔ Medicine/ Treatment cabinet
- ✔ Clinic furnitures
- ✔ Office/writing table
- ✔ Stock cabinet
- ✔ Chairs
- ✔ Footstool
- ✔ Waste can with cover
- ✔ Clinic linens like bedsheets,face towels,pillowcases, mattress
- ✔ Oxygen tank
- ✔ Oxygen Cannula
- ✔ Oxygen gauge
- ✔ Wheel chair
- ✔ Nebulizer

B.MACHINES AND USES

- ✔ Ophthalmic Ointment- Eye infection

- ✔ Eye Drops -Eye wash
- ✔ Cough syrup/ tablets -cough
- ✔ Nasal Decongestants -Colds
- ✔ Antispasmodics -Abdominal pain
- ✔ Antacids- Hyperacidity
- ✔ Antidiarrheal/ Oral hydration tablet- Loose bowel movement
- ✔ Analgesics/ Antipyretic-Headache/fever
- ✔ Aromatic Spirit of ammonia- Fainting, dizziness
- ✔ Tincture of Arnica-Hematoma/sprain
- ✔ Anti -allergy tablets-allergy
- ✔ Calmoseptine-Urticaria, Allergy
- ✔ Topical Ointment-Infected wounds
- ✔ Antiseptics disinfectant
- ✔ Lysol 10%-for disinfecting for forceps, other instruments.

A. Supplies and other equipment

- ✔ Cotton, cotton balls, cotton pledgets
- ✔ Gauze bandages
- ✔ Plaster/ adhesive tape
- ✔ Band-aid strips
- ✔ Soap dish with soap
- ✔ Medicine glasses

- ✔ Pair of scissors
- ✔ Pair of forceps
- ✔ Medicine Droppers
- ✔ Applicators, tongue depressors
- ✔ Kidney Basin
- ✔ Drinking glasses
- ✔ Tray
- ✔ Clinical Thermometer
- ✔ Ice cap
- ✔ Hot water bag
- ✔ Bottles/jar for cotton balls,cotton pledgets
- ✔ Elastic Bandage

Chapter 8

Glossary

XXV. DEFINITION OF TERMS

1. School Clinic-is a healthcare facility that is primarily focused on the care of the students and school personnel

2. School Health Services-are services provided through the school system to improve the health and wellbeing of children and in some cases whole families and the broader community.
3. Student Health Record-document containing information about the students health
4. Confinement- lying-in
5. First-Aid- is the first aid and immediate assistance given to any person suffering from either a minor or serious illness or injury, with care provided to preserve life, prevent the condition from worsening or to promote recovery
6. Hospital- is a health care institution providing patient treatment with specialized medical and nursing staff and medical equipment
7. Medicines-any substance or substance used in treating disease or illness
8. Vaccination-is the administration of vaccine to help the immune system
9. Asthma-is a common long-term inflammatory disease of the airways of the lungs ; it is characterized by variable and recurring symptoms, reversible airflow
10. Hyperventilation-it is a condition in which you start to breathe very fast
11. Contagious disease-it is an infectious disease communicable by contact with one who has it with a bodily discharge of such a patient or with an object touched by such patient or bodily discharge.
12. Hypertension- abnormally high blood pressure
13. Starting dose- initial dose/ first dose
14. Fainting-loss of consciousness for a short time because of temporarily insufficient supply of oxygen to the brain
15. Dizziness- a sensation of spinning around and losing one's balance
16. Hematoma-a solid swelling of clotted blood
17. Sprain-wrench /twist the ligaments of (an ankle,wrist, or other joint) violently as to cause pain and swelling but not dislocation
18. Disinfectant- a chemical liquid that destroys bacteria
19. Analgesic- a painkiller; drugs act in various ways on the peripheral and central nervous system
20. Antipyretic- use to prevent or reduce fever
21. Antispasmodics-use to treat various medical conditions that involve contraction and relaxation of muscle

22. Antacids-neutralize (reduce) excess stomach acid to relieve heartburn, sour stomach, acid indigestion and stomach upset
23. Fever-an abnormally high body temperature, usually accompanied by shivering, headache and in severe instances delirium
24. Lesions- a region in an organ or tissue which has suffered damaged through injury or disease such as wound,ulcer ,abscess or ulcer
25. Topical Ointment- a thick substance, that is put on the skin where it is sore or where there is injury, in order to cure it.
26. Nurse- a person whose job is to care for people who are ill or injured, especially in hospital
27. Doctor-a person with a medical degree whose job is to treat people who are ill or hurt
28. Dentist- a person whose job is treating peoples teeth
29. Over the counter medicines-a drug that is available over the counter, you can buy it in a shop without having to visit a doctor
30. Scabies- a contagious skin disease occurring especially in sheep and cattle and also in humans, caused by itch mite.
31. Immunocompromised- having an impaired immune system
32. Fully Vaccinated- it means you have inoculated the primary doses
33. Un vaccinated- not inoculated with a vaccine to provide immunity against the diseases.
34. Covid -19- it's an infectious disease caused by the SARS- COV 2 virus.

Chapter 9

References and Resources

XXVI. REFERENCES

https://dictionary.cambridge.org/dictionary/english/

https://medlineplus.gov/medicines.html

MIMS Drug Reference Philippines 2018- Issue2

PRUDENTIAL GUARANTEE, Personal Accident Insurance Policy

DepEd School Nursing Procedures Chapter IV(from 1997 DepEd School Manual)

https://dirp4.pids.gov.ph/webportal/CDN/PUBLICATIONS/pidspjd13-health%20care.pdf

issued Dep.Ed,Medical Certificate/ dental certificate for Athletes

https://arcadia.sch.ae/pdf/KCH-School-Clinic-Manual.pdf

Chapter 8

Appendix

Student's Information Sheet

CONTACT INFORMATION

Grade/Year : _____

School Year : _____

Name : _____

Last *First* *Middle*

Date of Birth : _____ Gender _____ Religion _____

Home Address: _____

Number and Street

_____

City/Town *Province* *ZIP*

Home Phone : _____

Father's Name: _____

Contact Information:

Office : _____ Mobile: _____ email: _____

Mother's Maiden Name: _____

Contact Information:

Office : _____ Mobile: _____ email: _____

Please list up to three (3) people whom we can contact in case of emergency:

NAME	*RELATION*	*HOME PHONE*	*WORK/CELLPHONE*

Physician to be called in case of emergency

NAME OF PHYSICIAN	*HOME PHONE*	*CLINIC/CELLPHONE*

Child's Medical History

Indicate any childhood disease your child has had:

_____chicken pox ____Scarlet fever _____mumps _____Measles _____rubella
_____dengue ____Hepatitis _____Asthma _____hay fever _____diabetes
_____hemophilia ____seizures _____others _____

Indicate whether your child suffers frequently from any of the following:

_____tonsilitis _____earaches _____stomachache _____diarrhea
_____vomiting _____ high fever _____constipation
Other _____

List any allergies your child may have and the treatment for each (food allergies, skin allergies, medication allergies, etc.) _____

_____

Has your child had any form of surgery or hospitalization? If yes please detail

_____

_____

Is your child currently taking any form of medication?

_____

Does your child have any other illness, past or present?

_____

Has your child had any broken bones, accidents or significant injuries?

_____

Does your child have any special or extreme fears? (for example: thunderstorm, loud noises, Dark, etc.)

_____

_____

MEDICAL HISTORY

Indicate below if this student has ever experienced any of the problems listed below. Please write in the Remarks column if there is anything we need to know about his/her health condition.

ITEM	*REMARKS*	*YEAR*	*ITEM*	*REMARKS*	*YEAR*
Eyes e.g. • Corrective Lenses/ Contacts • Other vision problems			**Genito-urinary** e.g. • Urinary tract Infections • Stones • Other urinary/ bladder problems		
ENT (Ear, Nose, Throat) e.g. • Hearing problems • Nose and throat problems • Other ear problems			Neurological e.g. • Convulsive disorders • Migraine • Headaches • Others		
Cardiovascular e..g. • Hypertension • Palpitations • Other heart problems			Endocrine e.g. • Diabetes • Thyroid • Others		
Respiratory e.g. • Asthma • Other respiratory problems			Musculo-skeletal e.g. • Back disorders • Diseases or injuries of the joints • Others		
Gastro-intestinal e.g. • Hyperacidity • Others			Hematological e.g. • Anemia • Others		

IMMUNIZATION RECORD			
VACCINE	**IDEAL TIME FOR ADMINISTRATION**	**ACTUAL AGE GIVEN**	**DATE GIVEN**
B.C.G. (Bacillus Calmette-Guerin)	Given at earliest possible time at birth or after birth.		
M.M.R (Measles, Mumps Rubella) 2 doses required	Dose 1 given at age 12-15 months or later		
	Dose 2 given at age 4-6 years or later, and at least 1		
D.P.T (Diphtheria, Pertussis, Tetanus) 3 doses required with 2 Booster shots	Dose 1 given at 6 weeks		
	Dose 2 given 4 weeks after 1st dose		
	Dose 3 given 4 weeks after 2nd dose		
	Booster 1 given 4 weeks after the 3rd dose		
	Booster 2 given between ages 4-6 years		
Hepatitis B 2 doses required with 2 booster shot	Dose 1 given at age 4 weeks		
	Dose 2 given 4 weeks after 1st dose		
	Booster dose given 4 months after 2nd dose		
Polio 3 doses required with 2 booster shots	Dose 1 given at 6 weeks		
	Dose 2 given 4 weeks after 1st dose		
	Dose 3 given 4 weeks after 2nd dose		
	Booster 1 given 4 weeks after 3rd dose		
	Booster 2 given between ages 4-6 years		
Hemophilus Influenza B 3 doses required with 2 booster shots	Dose 1 given at 6 weeks		
	Dose 2 given 4 weeks after 1st dose		
	Dose 3 given 4 weeks after 2nd dose		
	Booster 1 given 4 weeks after 3rd dose		
	Booster 2 given between ages 4-6 years		
Measles 1 dose required	Given at 9 months or later		
Varicella 1 dose required	Given at 12 months or later		
Hepatitis A 1 dose required	Given at age 2 years or later		

Parent / Guardian's Name & Signature

PHYSICAL EXAMINATION RECORD			
IMPORTANT: *TO BE FILLED OUT BY THE STUDENT'S CARE PROVIDER (PEDIATRICIAN/ FAMILY DOCTOR)* *Please review the student's history, complete the clinician's form and comment all positive answers*			
Blood Pressure:	**Blood Type:**	**Height :**	**Weight:**
Eyes			
Ears			
Nose			
Throat			
Neck			
Lungs			
Heart			
Abdomen			
Lymph glands			
GU			
Skin			
Neurologic			
Musculoskeletal			
ALLERGIES			
Is this student allergic to any of the following?			
Please specify them.			
Is this student medically qualified to participate in sports and other rigorous training activities like Scouting.			

Date :

Physician:_____

Lic. No :_____

MEDICAL CLINIC
HEALTH EXAMINATION RECORD
S.Y. 2018-2019

Child's Name: _____ Age/Sex: _____
Address: _____ Level/ Section: _____
Tel. No. _____ Contact Person: _____

HISTORY

1. Present Complaints: _____
2. Past Disease: _____
3. Previous Hospitalization/ Operation : _____

PHYSICAL EXAMINATION:

1. General Data

Bp _____ PR _____ Ht _____ Wt _____

2.

	NORMAL	FINDINGS
SKIN		
EENT		
NECK/ THYROID		
MOUTH/ THROAT		
CHEST/BREAST/ AXILAS		
LUNGS		
HEART		
ABDOMEN		
BACK		
GENITAL		
REFLEXES		
EXTREMITIES		

Date: _____

_____
School Doctor

XXVIII. Dental Forms

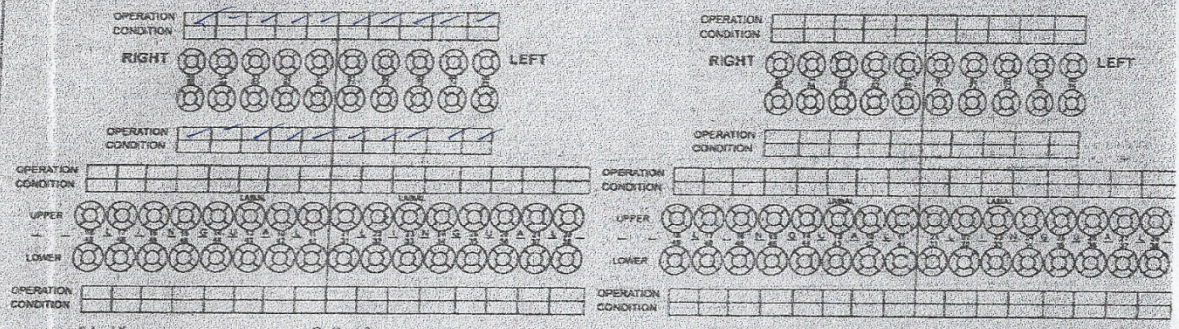
Einstein School for Kids – Cebu

Starting Them Young: "Every Child a Scientist with a Heart"
(032) 268-7623 / 0947-6328323

DHS Form 1

Name			Student No.	File No.
Surname	First Name	Middle Name		
Permanent Address		Residence Phone No.	Date of Birth	Sex
Parent Guardian		Relation	Mobile Phone No.	
Address: (If living with guardian)			Office Phone No.	

DENTAL HEALTH STATUS



ORAL HEALTH CONDITION

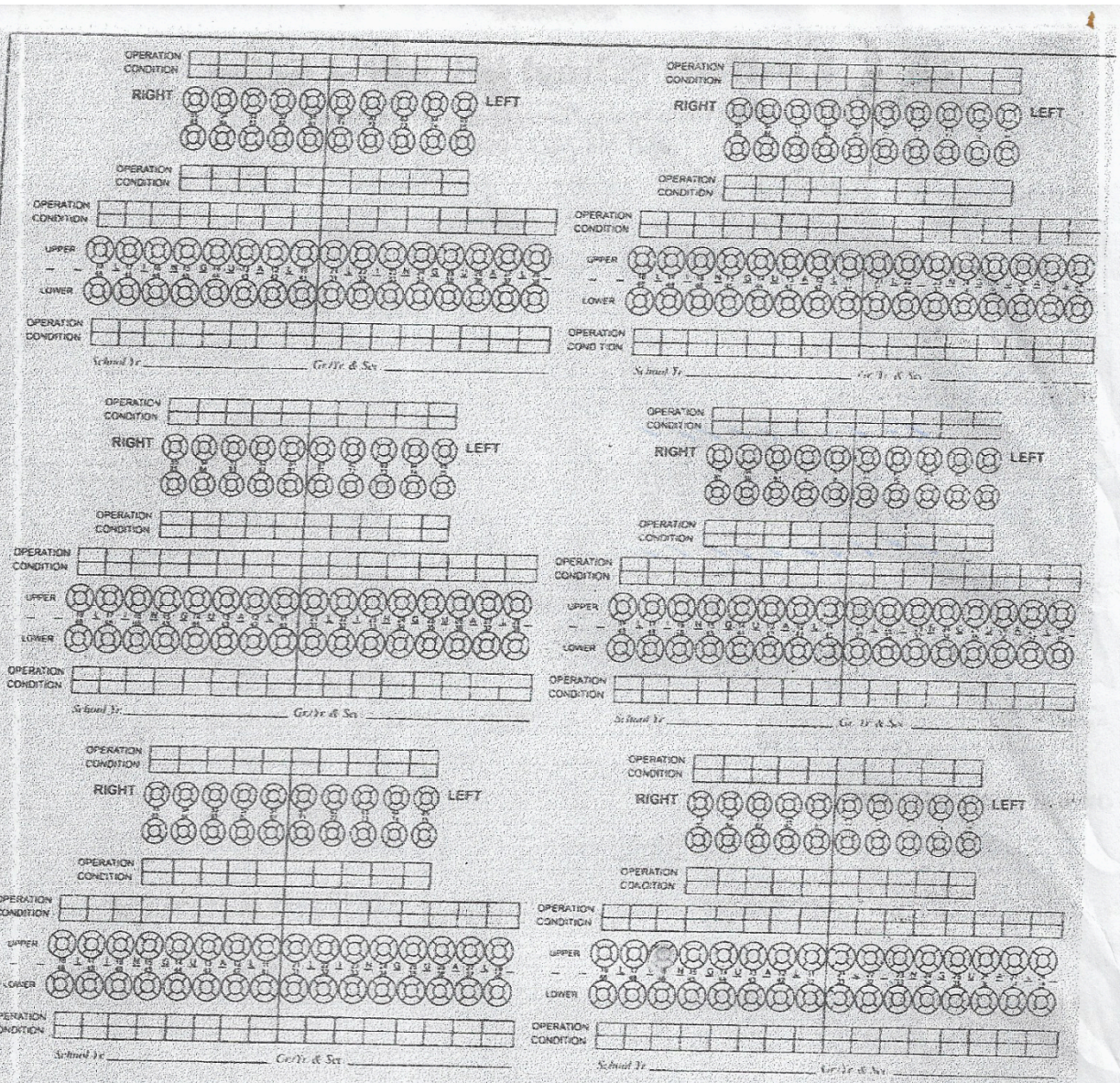
Date of Examination															
Age of Last Birthday															
Presence of Debris	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Inflammation of Gingiva	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Presence of Calcular Deposit	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Presence of Periodontal Pockets	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N
Under Orthodontic Treatment	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N	Y	N

Dentofacial Abnormalities and Other Oral Pathologic Diseases, Specify:

Tooth Count	T	P	T	P	T	P	T	P	T	P	T	P	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																
Examiner																

Legend:

J	- Caries Free	S	- Sealant	Tf	- Temporary Filling
D	- Decayed Tooth	Fb	- Fixed Bridge	Am	- Amalgam Filling
\	- Indicated for Extraction	Ab	- Abutment	Co	- Composite Filling
Rf	- Root Fragments	Sc	- Special Crown	Gf	- Gold Filling
M	- Missing / Extracted	P	- Pontic	Jc	- Jacket Crown
Un	- Unerupted	CD	- Complete Denture		



PAST MEDICAL AND DENTAL HISTORY : (-) Absence, (+) Presence; Please specify:

Allergy: _____ **Diabetes:** _____ **Blood Dyscrasia:** _____

CNS Disorder: _____ **Cardiovascular Disease:** _____ **Others:** _____

Dental Surgical Procedure/s Done: _____

RECORD OF CONSULTATION / SERVICES RENDERED

Date	*Time*	*Diagnosis*	*Tooth no.*	*Services Rendered*	*Recommendations*	*Dentist*

Einstein School for Kids – Cebu

"Starting them Young: Every Child a Scientist with a Heart"

DENTAL EXAMINATION FINDINGS AND RECOMMENDATION

Name: _____ **Age/Sex:** _____

DOB: _____ **Level/ Sec:** _____

ORAL EXAMINATION REVEALED THE FOLLOWING CONDITIONS

_____Caries-free
_____Poor Oral Hygiene
_____Gum Infection (Gingivitis, Periodontal Pockets)
_____Restorable Carious Tooth/Teeth
_____Non-restorable Carious Tooth/Teeth
_____Others Specify: _____

REMARKS AND RECOMMENDATION/S:

_____Need personal attention in tooth brushing
_____For Oral Prophylaxis/ Fluoride application
_____For Gum Periodontal Treatment
_____For Orthodic Consultation
_____For Filling Tooth #: _____
_____ For extraction Tooth #: _____
_____For Endodontic Treatment: Tooth #: _____
_____For Radiographic: Specify: _____
_____Need Prosthesis: Specify: _____
_____Medical Clearance
_____Others Specify: _____

Our student's dental health is our major concern. Kindly give this matter prompt attention and have an appointment with your family dentist. Thank You for your cooperation.

Date: _____ _____
School Dentist

RETURN SLIP

Date: _____

DR. _____
School Dentist

This is to inform you that I have rendered necessary dental procedure/s enumerated hereunder to _____ of _____.
(student) (Level & Sec)

TREATMENT/ PROCEDURE/S DONE:

1.
2.

REMARKS: _____

_____

_____
Attending Dentist
License No.: _____

Republic of the Philippines
DEPARTMENT OF EDUCATION
REGION VII CENTRAL VISAYAS
Region
LAPU-LAPU CITY
Division

DENTAL HEALTH RECORD

Latest 1½ x 1½ picture

Name: _____ Date _____
Age: _____ Sex _____ Birth Date _____
Event: _____
Parent/Guardian: _____
Coach: _____

CONDITION AND TREATMENT NEEDS

CONDITION RIGHT	55	54	53	52	51	61	62	63	64	65	LEFT					
TEMPORARY TEETH																
	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
PERMANENT TEETH																
	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38
CONDITION																
TREATMENT NEEDS																
TEMPORARY TEETH																
RIGHT	85	84	83	82	81	71	72	73	74	75	LEFT					
CONDITION																

GINGIVITIS								
PERIODONTAL DISEASE								
MALOCCLUSION								
SUPERNUMERARY TOOTH								
RETAINED DECIDOUS								
DECUBITAL ULCER								
CALCULUS								
CLEFT PALATE								
ROOT FRAGMENT								
FLUOROSIS								
OTHERS (Specify)								

YEAR LEVEL								REMARKS
DATE								
EXAMINATION								
SEALANT (GI)								
PERMANENT FILLING								
ART								
EXTRACTION								
ORAL PROPHYLAXIS								
REFERRAL								
OTHER ORAL TREATMENT								

	DATE OF VISIT						
TEMPORARY TEETH							
INDEX D.F.T.							
NO. T /DECAYED							
NO. T/ FILLED							
TOTAL D.F.T.							

TEMPORARY TEETH							
INDEX D.F.T.							
NO. T /DECAYED							
NO. T/MISSING							
NO. T/ FILLED							
TOTAL D.F.T.							
TOTAL SOUND TEETH							

SYMBOLS FOR MOUTH EXAMINATION

- X - TOOTH INDICATED FOR EXTRACTION
- F - TOOTH INDICATED FOR FILLING
- HEAVY SHADE - TOOTH WITH TEMPORARY FILLING
- RC - RECURRENT CARIES
- RF - ROOT FRAGMENT
- M - MISSING TOOTH
- DU - DECUBITAL ULCER
- MAL - MALOCLUSSION
- FLU - FLUOROSIS
- Gn - NORMAL
- Gm - MODERATE GINGIVITIS (1-2 QUADRANTS)
- Gs - SEVERE GINGIVITIS (3-4 QUADRANTS)
- CMR - COMPLETE MOUTH REHAB
- (√) - SOUND ERUPTED PERMANENT TOOTH

SYMBOLS FOR ACCOMPLISHMENT

- XT - EXTRACTED PERMANENT TOOTH
- xt - EXTRACTED TEMPORARY TOOTH
- Am - AMALGAM FILLING
- Com - COMPOSITE FILLING

ARTIFICIAL RESTORATION

- JC - JACKET CROWN
- I - INLAY
- OP - ORAL PROPHYLAXIS
- ZOE - ZINC OXIDE UEGENOL FILLING
- TF - TEMPORARY FILLING
- R - REFERRED TO PRIVATE DENTIST
- UN - UNERUPTED TOOTH

Division Meet DENTIST *(signature over printed name)* PRC: LICENSE:	Remarks/Findings: Date Examined:
Regional Meet DENTIST *(signature over printed name)* PRC: LICENSE:	Remarks/Findings: Date Examined:
Palarong Pambansa DENTIST *(signature over printed name)* PRC: LICENSE:	Remarks/Findings: Date Examined:

XXIX. Medical Certificate

Republic of the Philippines
DEPARTMENT OF EDUCATION
RO-7
(Region)
LAPU-LAPU CITY DIVISION
(Division)

_____
(School)

_____
(School Address)

MEDICAL CERTIFICATE

_____
(Date)

To Whom It May Concern:

This is to certify that I have personally examined

Name

_____ age _____ sex _____ born on

_____ and have found that he/she is physically fit, during the time of examination, to join and compete in the lower meets and Palarong Pambansa.

Event: _____

Physical Examination

Date examined: _____
Height _____ Weight: _____ Blood Pressure _____
Pulse, Resting _____ Respiratory Rate _____
Other Remarks: _____
_____
_____

_____
Physician/Medical Officer
(Signature over printed name)

License No. _____
PTR.: _____
Date: _____

R.E.J. Camalongay Doctors Clinic

Unit 3, De Asis Building, Sudtunggan Road,
Basak, Lapulapu City, Cebu, Philippines 6015
(63) 0923-359-6061 (Mobile)/ (032) 494-3917 (Landline)

MEDICAL CLEARANCE

PARTICIPANT INFORMATION:

Name: _____ Age/Sex: _____ DOB: _____
Address: _____ Mobile No.: _____
School: _____ Grade/Section: _____
Activity: _____ Event Date: _____

PERSONAL HEALTH INFORMATION:

- ☐ Physical Deformities
- ☐ Physical Disability
- ☐ Asthmatic
- ☐ Allergic Rhinitis
- ☐ Allergies: _____
- ☐ Current illness: _____
- ☐ History of fracture
- ☐ History of sprain
- ☐ History of seizure
- ☐ History of fainting spells
- ☐ On medication(s): _____

PHYSICAL EXAMINATION:

BP: _____ mmHg HR: _____ bpm RR: _____ cpm Temp: _____ ºC

Height: _____ cm Weight: _____ kg BMI: _____ (_____)

Wearing eyeglasses : _____ Pertinent Findings: _____

ASSESSMENT:

- ☐ Participant is physically and mentally fit at the time of examination.
  - o Participant may join the activity without restrictions.
  - o Participant may join the activity with the following restrictions: _____
- ☐ Participant is unfit to join the activity.

Dr. Rose May D. Camalongay
Examining Physician
Lic. No. 0115564

_____
Participant's Signature over Printed Name

Date Examined: _____

XXX. Claim Statement Form (AXA Philippines)

PERSONAL ACCIDENT INSURANCE
CLAIM REPORT FORM

NOTE: TO BE ACCOMPLISHED BY THE PRINCIPAL INSURED OR BENEFICIARY OR CLAIMANT

Principal Insured : _____ Policy No. : _____

Claimant's Name : _____ Relationship : _____

Address : _____ Email Address : _____

Birthday of Insured : _____ Tel. No. : _____

Occupation of Insured : _____ Fax. No. : _____

1. Date of Accident : _____
2. Place of Accident : _____
3. Nature of the injury of the Insured : _____
4. Briefly discuss how the accident occurred/happened : _____
5. Was the Insured confined? If yes, please indicate period of confinement and name of hospital : ☐ Yes ☐ No
   From: _____ To: _____
   Name of Hospital: _____
6. Details of physicians consulted: (use another sheet of paper if space is not enough)
   Name: _____
   Address: _____
   Telephone Number: _____
   Name: _____
   Address: _____
   Telephone Number: _____
7. Do you have accident insurance or HMO with other companies? If yes, please indicate name & contact details of the company ☐ Yes ☐ No
   Company: _____
   Address: _____
   Company: _____
   Address: _____

DECLARATION and ANTI-FRAUD NOTICE

I/We confirmation that I am/We are the claimant and/or the Policyholder and I/We declare that all the particulars given above are to the best of my/our knowledge true and correct and that I have not withheld from the Company and material information in connection with this claim.

I hereby confirm that I am fully aware of the consequences of any misrepresentation or concealment on my part pursuant to Sections 29 and 251 of the Insurance Code, as amended, which reads:

Section 29. An intentional and fraudulent omission, on the part of one insured, to communicate information of matters proving or tending to prove the falsity of a warranty, entitles the insurer to rescind.

Section 251. It is unlawful to:
(a) Present or cause to be presented any fraudulent claim for the payment of a loss under a contract of insurance; and
(b) Fraudulently prepare, make or subscribe any writing with intent to present or use the same, or to allow it to be presented in support of any such claim. Any person who violates this section shall be punished by a fine not exceeding twice the amount claimed or imprisonment of two (2) years, or both, at the discretion of the court.

AUTHORIZATION

Where applicable. I/We hereby authorize any hospital physician or other person who has attended or examined me to furnish to the Charter Ping An Insurance Corporation or to its Authorized Representative any and all information with respect to any injury, medical history, consultation, prescription or treatment and copies of all hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the original.

DATE PRIVACY CONSENT

In connection with my/our and/or the claimant's claims I/We give consent for Charter Ping An Insurance Corporation ("AXA") and their respective representatives or agents to collect, use, store, transfer and/or disclose the information (including that provided by sources other than myself) concerning me/us and/or the claimant, to or with all such persons (including any member of AXA Group or any third party service provider, or whether within or outside the Philippines and the policyholder when claiming under Group Policy) for the purpose of enabling AXA and their respective representatives or agents to provide me/us and/or the claimant (where applicable) with services required of an insurance provider, including the evaluation, processing, administering and/or managing my/our and/or claimant's claims or the Policyholder Group Policy(ies) with AXA (as the case may be)

Where I/we have provided information about another individual, I/we confirm that I/we have provided notice to and obtained the consent of the individual in the manner required the Data Privacy Act of 2012.

This report was filed on (mm/dd/yyyy) _____ at (AXA PH Office or branch) _____

_____ Place

_____ Signature of Insured/Claimant

CHARTER PING AN INSURANCE CORPORATION
Under the trade name AXA Philippines
29th Floor GT Tower International, 6813 Ayala Ave. cor. H.V. Dela Costa St., Makati City, Philippines 1227
Customer Care Hotline +63 2 5815 292 • customer.service@axa.com.ph • www.axa.com.ph

INSTRUCTIONS TO CLAIMANTS

1. Ask the attending physician to accomplish the Attending Physician's Statement if no Medical Certificate is available.
2. Attach all the necessary documents as per Checklist below.
3. Submit the above documents for the nearest AXA/Charter Ping An Insurance Corporation office or to the servicing agent.

CHECKLIST

1) ACCIDENTAL DEATH CLAIM

a) Attending Physician's Statement or Medical Certificate (original or certified true copy)
b) Police investigation Report or Statement of Witness/es (original or certified true copy)
c) Birth Certificate (original or certified true copy)
d) Death Certificate with Post Mortem Examination (original or certified true copy)
e) Autopsy Report - if available (original or certified true copy)
f) Marriage Contract (original or certified true copy)
g) Burial & Funeral Services Contract (Photocopy only)
h) Official Receipts for the Burial & Funeral Services (original only) - if there is coverage and is claiming under Accidental Burial Expense coverage
i) Certificate of Employment (for Group Personal Accident Insurance - original or certified true copy)
j) Certificate of Bona-fide Student (for Student Personal Accident Insurance - original or certified true copy)
k) Official Receipts for Medical Expenses (original only)
l) Hospital Records (photocopy only) (if available)

2) MEDICAL REIMBURSEMENT CLAIM AND/OR DISABLEMENT CLAIM

a) Attending Physician's Statement or Medical Certificate (original or certified true copy)
b) Police Investigation Report or Statement of Witness/es (original or certified true) Police Investigation Report or Statement of Witness/es (original or certified true copy)
c) Official Receipts for Medical Expenses (original only)
d) Picture of disabled body part (for Disablement Claim only)
e) Hospital Records (photocopy only) (if available)

ATTENDING PHYSICIAN'S STATEMENT

In respect of the accident to _____

I DO HEREBY CERTIFY that I personally examined the injuries sustained by the above person named in the accident described herein, and that the said injuries are as follows:
Nature & extent of injury _____
_____
_____
State as fully as possible the cause of accident _____
_____
_____
Is the appearance of the injury consistent herewith? _____
_____
Is there any connection between the present disablement and any disease or previous accident? If so, please give details
_____
_____
Is surgical interference necessary or likely to become so? ☐ YES ☐ NO. Please explain briefly: _____
_____
What was the medical management? _____
Is the patient now, or was he at the time of the accident, subject to or suffering from any illness or disease irrespective of the injury? _____ If so, state (a) the nature of the same (b) the probable duration thereof (c) the extent to which it has affected the patient's recovery _____
_____
Has the patient been confined to the hospital/house by your Instructions? _____
If so, state inclusive dates: from _____ to _____
Please state the date when the patient can resume work: _____
Is the patient permanently disabled? If yes, please indicate details: _____
_____

_____	_____	_____
Date	Physician's Name (print please)	Signature
_____	_____	_____
License No.	Address	Tel. No.

CHARTER PING AN INSURANCE CORPORATION
Under the trade name AXA Philippines
29th Floor GT Tower International, 6813 Ayala Ave. cor. H.V. Dela Costa St., Makati City, Philippines 1227

XXXI. Contact Tracing Forms and Health Declaration Form

EINSTEIN SCHOOL CEBU

Student Contact Tracing Form

Name:	Date (MM/DD/YY):
Section:	Time:
Contact Number:	Body Temperature:
Complete Current Address:	Teachers in Contact With:

I hereby authorize Einstein School Cebu to collect and process the data indicated herein for the purpose of contact tracing effecting control of the COVID-19 transmission. I understand that my personal information is protected y RA 10173 or the Data Privacy Act of 2012 and that this form will be destroyed after 30 days from the date of accomplishment, following the National Archives of the Philippines protocol.

Signature: _____

EINSTEIN SCHOOL CEBU

ABUNOL, PAJAC, LAPU-LAPU CITY
(032) 268-7633 | 0947-6328323
einsteinschoolcebu@gmail.com
http://www.einsteinschool.ph
https://www.facebook.com/EinsteinCebu

HEALTH AND RISK DECLARATION FORM

PERSONNEL INFORMATION

Last Name: _____ First Name: _____ Middle Name: _____

Birthdate: _____ Age: _____ Cel #: _____

Residential Address *(where you stayed during the quarantine period; if multiple addresses, specify period of stay):*

_____

HEALTH AND TRAVEL QUESTIONNAIRE

Have you travelled to/ transited other cities/ provinces other than your place of residence in the past 14 days?	☐ Yes ☐ No *If yes, specify*
Have you been to a medical facility, i.e. hospitals, health center, testing center, etc. in the past 14 days?	☐ Yes ☐ No *If yes, specify*
Have you been listed as PUI, PUM, etc.?	☐ Yes ☐ No *If yes, specify*
Have you undergone testing for COVID-19?	☐ Yes ☐ No *If yes, specify*
Have you been sick in the past 30 days?	☐ Yes ☐ No *If yes, specify*
Did you experience any of the following in the past 14 days? (Please tick symptom(s) that applies to you) ☐ Fever ☐ Cough ☐ Loss of Smell / Taste ☐ Shortness of Breath ☐ Colds ☐ Diarrhea ☐ Muscle Aches ☐ Sore Throat	
Did anyone you are residing with or have been in close contact with experience any of the above mentioned conditions in the past 14 days?	☐ Yes ☐ No *If yes, specify*
Have you, or anyone you have been in close contact with, been diagnosed with COVID – 19 or been placed on quarantine for possible COVID-19?	☐ Yes ☐ No *If yes, specify*
Are you residing with anyone who may be considered as high-risk such as: (please check all that applies to you) ☐ Aged below 21 ☐ Aged 60 years old or older ☐ With co-morbidities or pre-existing illness ☐ Assessed as having a high-risk pregnancy	

I certify that all information provided herewith is true and correct.

_____
Signature over Printed Name