Medical History

1. Do you have any allergies? __ Yes __ No if Yes, please identify below.
   __ Medicine
   __ Pollens
   __ Food
   __ Stinging Insects
   __ Others: ____

2. Do you have any ongoing medical condition? __ Yes __ No If Yes, please identify below:
   __ Error of refraction
   __ Asthma
   __ Seizure
   __ Heart problem
   __ Anemia
   __ Bleeding disorder
   __ Hernia (painful bulge in the groin area)
   __ Others: ____

3. Have you ever had surgery/ hospitalization? __ Yes __ No. if Yes, please specify details.____

4. Does anyone in your family have the following conditions:
   __ Tuberculosis
   __ Cancer If yes, what kind? ________________________________
   __ Stroke
   __ Diabetes Mellitus
   __ Hypertension
   __ Depression
   __ Others: ____

5. Exposure to cigarette/vape smoke at home? __ Yes __No

I certify that the above information are correct.

______________________________________ ________________________

Name & Signature of Parent/Guardian Date

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Name of Learner