Philhealth ID No.(If Any): PWD ID(If Any): Last Name: First Name: Middle Name: Contact No.: House No. & Street Name/Zone: Barangay: Municipality:			VACCINATION ADMISSION FORM									
			Philhealth ID No.(If Any):									
			Middle Name: Contact No.: House No. & Street Name/Zone: Barangay: Municipality:									
								Birthdate://			Birthdate://_	
							Civil Status:			Civil Status:		
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							Pls.	Conditions	Specify	Pls.	Conditions	Specify
							(√)Check	ALLERGY		(v)Check	ALLERGY	
				Hypertension			Hypertension					
	Heart Disease			Heart Disease								
·	Kidney Disease			Kidney Disease								
-	Diabetes	Туре		Diabetes	Туре							
	Asthma			Asthma								
	Cancer		_	Cancer								
	Others Diagnosed with Covid-19	Date:	_	Others Diagnosed with Covid-19	Date:							
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Diagnosed with Covid-19

Date:

Diagnosed with Covid-19

Date: