MEDICAL FORM

S. No. | | | | | | | | | |

BHADBHADA ROAD, BISHENKHEDI, BHOPAL - 462 044, M.P.

1. ______________________________
Name of the Student

______ Class ______ Section ______ Roll No. ______ Date of Birth

2. ______________________________
Name of Sibling, if studying in the School

______ Class ______ Section ______ Roll No.

3. Parental Detail

Mother	Father
Name	Name
Mobile No.	Mobile No.
Office Telephone	Office Telephone
Email ID	Email ID

____
Residential Address

______ City ______ State ______ Pin Code

______ Residential Tel No. ______ Emergency Tel No.

4. Person apart from parents to be contacted in case of emergency

____
Name

____
Relation

____
Address

Telephone

______ Mobile ______ Residence ______ Office

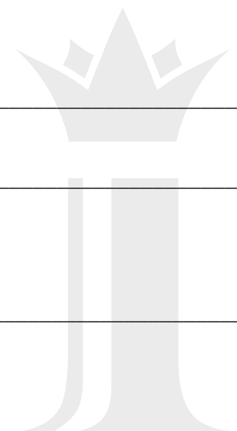
5. Family Physician

____
Name

____
Address

Telephone

______ Mobile ______ Residence ______ Clinic



6. Medical History

Please read the following instructions carefully before filling up the form.

- Each column should be filled by the parent in consultation with medical practitioner.
- Please use the reverse side of the form for additional information, if necessary.
- No column should be left blank.

Health Record

S.No.	Health Problem	Details	Remarks if any
1	Allergies		
2	Asthma		
3	Neurological Problems		
4	Throat infection		
5	Diabetes		
6	Frequent Ear Infections		
7	Eye Problem		
8	Skin Problem		
9	Glasses/Contact Lenses		
10	Hearing Difficulty		
11	Kidney/Urinary Problems		
12	Emotional Psychological Problems		
13	Orthopedic/Bone Problem		
14	Any Other		

Blood Group ______________________ Rh factor ______________________

Dental

a. Has your ward been recently checked by a Dentist ☐ Yes ☐ No

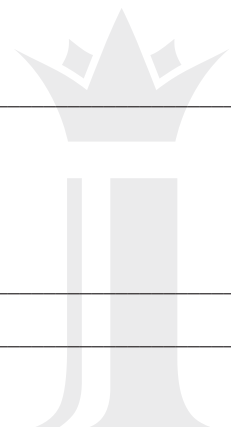
b. If yes, please furnish the details

Recent or past illness

a. Has your child suffered from any serious illness in the past ☐ Yes ☐ No

b. If yes, give details including year, diagnosis & treatment

Other Information
Any other information relating to health of your ward, that you wish to indicate



7. Immunization Record

S.No.	Type of immunizations	Date 1st Dose	Date 2nd Dose	Date 3rd Dose	Date 4th Dose	Date 5th Dose
1	B. C. G					
2	D. P. T.					
3	Oral Polio					
4	MMR					
5	Mumps					
6	Typhoid					
7	Cholera					
8	Hepatitis, A™					
9	Hepatitis, B™					
10	Tetanus Toxoid					
11	Chickenpox					
12	Any Other					

This is to certify that Master, Miss ________________________________ Age __________
Is examined by me and has been found fit to undertake the academic and co-curricular activities of the School Curriculum.

Signature of Medical Examiner

Signature of Parent

Name

Name

Registration No. and Seal

Place

Date

FOR OFFICIAL USE ONLY (TO BE FILLED IN BY SCHOOL PHYSICIAN)

1. General Examination: Height (cms) Weight (Kgs.)
2. VN Vision: Colour Blindness BP Pulse Nails Conjuctiva
3. Systemic Examination

CNS

CVS

P/A

R/S

4. Summary ☐ FIT ☐ UNFIT

Comments

Date

Signature of Doctor