

FOR OFFICIAL USE ONLY
(To be filled by RMO)

GENERAL EXAMINATION

Date: _____

Height: _____ cms Weight: _____ Kgs.

VN VISION

Colour Blindness: _____ BP: _____

Pulse: _____ Nails: _____

Conjunctiva: _____

SYSTEMIC EXAMINATION

CNS: _____

CVS: _____

P/A: _____

R/S: _____

SUMMARY: Fit Unfit

Comments: _____

Documents List:

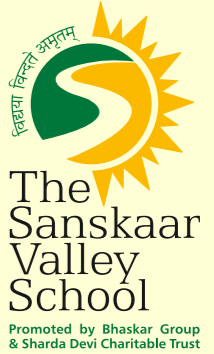
Allergy Report	()	Frequent Ear Infection	()	Skin Problems	()
Blood Report	()	Hearing Difficulty	()	Eye Problems	()
HbA1c Report	()	Kidney/ Uninary Problem	()	Glasses/ Contact Lenses	()
Orthopaedic/ Bone Problems	()	Counsellor's Report	()		

Date

Signature of Doctor (RMO)

MEDICAL FORM
Personal Particulars

The Sanskaar Valley School, Chandanpura, Bhopal-462016. Ph.: +918889533346 - 49



Name of the Student: _____

Class: _____ **Section:** _____ **Student's ID:** _____

Date of Birth: _____

Name of Sibling if studying in school: _____

Class: _____ **Section:** _____ **Student's ID:** _____



Parental Details

Mother

Name : _____

Email : _____

Mobile No. : _____

Alternate Mobile No. : _____

Residential Address : _____

Father

Name : _____

Email : _____

Mobile No. : _____

Alternate Mobile No. : _____

Residential Phone Number (s) : _____

Local Guardian to be contacted in case of an emergency:

Name : _____

Relation : _____

Address : _____

Telephone: Office: _____ Residence: _____ Mobile: _____

Alternative Mobile No. : _____

Family Physician:

Name: _____

Address (Clinic): _____

Telephone: Clinic: _____ Residence: _____ Mobile: _____

Email : _____

MEDICAL HISTORY

Please read these instructions carefully before filling up the Form.

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

Health Record:

Health Problems	Yes/ NO	Remarks if Any
Allergies		Report to be submitted
Asthma		
Neurological Problems		Report
Throat Infection		Report
Diabetes		HbA1c Report
Frequent Ear Infections		Report to be submitted
Hearing Difficulty		Report to be submitted
Kidney/ Urinary Problem		Report to be submitted
Orthopaedic / Bone Problems		Report to be submitted
Skin Problems		Report to be submitted
Eye Problems		Report to be submitted
Glasses/ Contact Lenses		Report to be submitted
Emotional/ Psychological Problems		Counsellor's Report
Any Other		

Blood Group _____ **Rh Factor** _____ **(Report Required)** _____

Dental

- a. Has your ward been recently checked by a Dentist: Yes No
- b. If yes, please furnish the details _____

Recent or Past Illness (Physical Health & Mental/Emotional Well-being)

- 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 the health of your ward, that you wish to indicate and requires our attention.

Immunization / Vaccination Record (Copy to be attached)

Type of Vaccines	Administered	Not Administered
BCG Vaccines		
Hepatitis B Vaccine		
OPV		
IPV		
DTP (DTwP/DTaP) Vaccine		
Hib Vaccine		
Pneumococcal Vaccine		
Rotavirus Vaccine		
Influenza Virus Vaccine		
MMR Vaccine		
Typhoid Conjugate Vaccine		
Hepatitis A Vaccine		
Chickenpox (Varicella Vaccine)		
Tdap Vaccine		
HPV		
Any Other		

This is to certify that Master/ Miss _____ Age _____
has been examined by me and has been found fit to undertake all the academic and co-curricular activities as prescribed by the school curriculum.

Signature and Seal of Medical Practitioner

Signature of Parent

Name: _____

Name: _____

Registration No: _____

Place: _____

Date: _____

Seal: _____