FOR OFFICIAL USE ONLY

(To be filled in by School Physician)

GENERAL EXAMINATION

Height: ______________________ cms Weight: ______________________ Kgs.

VN VISION

Colour Blindness: ______________________ BP: ______________________

Pulse: ______________________ Nails: ______________________

Conjunctiva: ______________________

SYSTEMIC EXAMINATION

CNS: ______________________

CVS: ______________________

P/A: ______________________

R/S: ______________________

SUMMARY: ☐ **Fit** ☐ **Unfit**

Comments: ______________________

____

____

Date: ______________________

____
Signature of Doctor

MEDICAL FORM

Personal Particulars

The Sanskaar Valley School

Promoted by Bhaskar Group & Sharda Devi Charitable Trust

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

Name of the Student: ______________________

Class: ______________________ **Section:** ______________________ **Roll No.:** ______________________

Date of Birth: ______________________

Name of Sibling if studying in school: ______________________

Class: ______________________ Section: ______________________ Roll No.: ______________________

Parental Details

Mother

Name : ______________________

Office Telephone: ______________________

Email : ______________________

Mobile No. : ______________________

Father

Name : ______________________

Office Telephone: ______________________

Email : ______________________

Mobile No. : ______________________

Residential Address: ______________________

____

Residential Phone Number (s): ______________________

Person apart from parent to be contacted in case of emergency:

Name : ______________________

Relation : ______________________

Address : ______________________

Telephone: Office: ______________________ Residence: ______________________ Mobile: ______________________

Family Physician:

Name: ______________________

Address (Clinic): ______________________

____

Telephone: Clinic: ______________________ Residence: ______________________ Mobile: ______________________

Email : ______________________

MEDICAL HISTORY

Please read these instructions carefully filling up the Form.

- Each column should be filled bye 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 bank.

Health Record:

Health Problems	Details	Remarks if Any
Allergies		
Asthma		
Neurological Problems		
Throat Infection		
Diabetes		
Frequent Ear Infections		
Hearing Difficulty		
Kidney/ Urinary Problem		
Orthopaedic / Bone Problems		
Skin Problems		
Eye Problems		
Glasses/ Contact Lenses		
Emotional/ Psychological Problems		
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

____

____

Immunization Record

Type of Immunizations	Date Ist Dose	Date 2nd Dose	Date 3rd Dose	Date 4th Dose	Date 5thDose
B.C.G.					
Diphtheria Pertussis Tetanus (D.P.T)					
Oral Polio					
Measles, Rebella (MMR)					
Mumps					
Typhoid					
Cholera					
Hepatitis, A™					
Hepatitis, B™					
Tetanus Toxoid					
Chickenpox					
HIB					
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: ______________________

Seal and Registration No: ______________________

Place: ______________________

Date: ______________________