



**MEDICAL FORM**



**Name of Student:** \_\_\_\_\_  
**Date of Birth:** \_\_\_\_\_  
**Class / Sec:** \_\_\_\_\_

**Part - 1**

1. A through dental check - up / treatment must be completed during the vacations.
2. Only one Orthodontic visit per term is permitted for children who have got their orthodontic treatment from elsewhere. This information about Orthodontic visit must be given in the beginning of each term, duly signed by the Orthodontist.

Orthodontic follow-up: YES / NO

Name and contact number of Orthodontist:

3. In case your child uses glasses / contact lenses it is imperative that she / he brings 3 pair of glasses to school. Two of these are to be duly deposited with the Matron.
4. Vaccination schedule (**Please mention year and date of having given**)

BCG....., DPT....., MMR....., Measles.....

Tetanus: Booster at 10 Year - Yes / No..... Booster at 15 year-Yes / No.....

Meningitis; Yes / No.....

Influenza: Yes/No.....

5. When last dewormed.....

6. In the recent past did your child:

\* Suffer from any illness? .....

\* Undergo any Surgery? .....

\* Sustain any injury / fracture? .....

7. Fitness

The child is fit for extra curricular activities mentioned below [ **tick mark the activity for which the child is not fit** ]

PT / Games / Swimming / Hikes / Camps / Treks/ Athletics / Long Distance Runs / Gymnastics/ Any others.

8. **Consent**

I hereby consent to any form of treatment or surgery for my child, which is deemed necessary by the R.M.O, consulting surgeon / consulting physician/ dental specialist. I authorize the School Nurse to sign the consent on my behalf in case of any emergency / preventive dentistry /investigation/ routine vaccination, including Influenza. The entire expenses will be borne by me. This remains valid through out the stay of my child in the school.

Signature of Parent / legal Guardian

Date:

Name .....

Full Address.....

E mail address.....Skype ID.....

Telephone / Mobile No of the Parent / Guardian.....

**P A R T - I I**

***TO be filled by the Family Physician or General Practitioner or Medical Specialist***

**General Examination:**

Height .....cm.

Weight.....:kg .

Identification marks: .....

Pulse / min..... Blood Pressure .....mm Hg, Anemia / Jaundice.....

Cyanosis..... Clubbing .....Lymph node enlargement .....,

Edema.....

**Systemic Examination:**

Respiratory system: .....,

Cardio Vascular system: .....,

Central Nervous system: .....,

Abdomen .....,

ENT: ..... EYE : .....

Skin / hands. Nails / groin/ genitalia/ scalp .....

For Girls Menstrual history .....

**FIT / UNFIT FOR JOINING SCHOOL**

Date :.....

Signature

Registration No. ....

Official stamp