

MY HEALTH INFO

Name: _____ Gender _____ Class: _____

Address: _____

_____ Tel No. (Residence): _____

Date of Birth: _____ Age: _____

Mother's Name: _____ Mobile No.: _____

Father's Name: _____ Mobile No.: _____

Alternative person to be contacted in case of emergency; Name: _____

Tel No.: _____ Relationship with the child: _____

HEALTH RECORD

(To be filled by family doctor / Registered Medical Practitioner)

Date of Examination: _____ Blood Group: _____ (**Attach Report**)

General Examination:

Height: _____

Weight: _____

Pulse: _____

B.P.: _____

Hair: _____

Nails: _____

Skin: _____

Nutrition Status: _____

Systemic Examination:

Eyes: _____

Vision: R _____ L _____

Nose: _____

Ears: _____

Throat: _____ Speech: _____

Dental Exam: _____

Respiratory System: _____

Cardio Vascular System: _____

Muscular System: _____

Abdomen: _____

1. Serious illness the child has presently or had during early childhood

| | |
|---------------------|--|
| Any heart problem | |
| Asthma | |
| Convulsion / fits | |
| Genetic Disorder | |
| Blackouts | |
| Diabetes | |
| Hypertension | |
| History of surgery | |
| Any other (specify) | |

| | |
|--|----------|
| 2. Allergies (if any) | |
| I. Bee/Insect Stings | |
| II. Medicines (specify) | |
| III. Food (specify) | |
| If yes, What happens | |
| How severe | |
| Medicine to be taken | |
| 3. Physical Fitness | |
| Fit to participate in age specific physical activity | |
| Needs to take precautions | |
| Should not participate in competitive sports | |
| 4. Vaccination Completed | Yes / No |

Name & Stamp of the Doctor

Signature

To be filled by the Parents

Does your child take any medication on a routine basis.

Yes

No

If yes, give the details of the medicines that are currently being taken by your child

Name/s

Purpose

In school _____

At home _____

My child does/does not have any health issues presently

I understand that the school is well-equipped to provide first aid to students but whenever further treatment and management is required, the onus shall lie with the parents only. However, in case of any emergency, I authorize the school to take necessary action for the well-being of my child.

Date

(Name of the Parent)

(Parent's Signature)

Verified _____

(Dr. Anshu Asri)

Medical Officer