MY HEALTH INFO

Name: _____ 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