MEDICAL REPORT FORM

Students particulars

Name of the Student _____ Sex : M ☐ F ☐

Father's Name _____ Mother's Name _____

Registration No. ☐☐☐☐☐☐☐☐☐☐☐☐☐

Admission No. ☐☐☐☐☐☐☐☐☐☐☐☐☐

Identification
Mark _____

Blood Group _____ HB% _____ Height (CM) _____ Weight (KG) _____

History of any significant past
or present illness / prolonged illness Asthma ☐ Eplepsy ☐
Any Other : _____

General Medical Record
Is there any significant condition the school needs to be aware of about your child's main systems and organs ?

_____

_____

Student vaccination record (Tick below if applicable)

	Yes	No		Yes	No
BCG	☐	☐	H/b	☐	☐
DTP	☐	☐	Influenza	☐	☐
MMR	☐	☐	Typhoid	☐	☐
Polio	☐	☐	Measles	☐	☐
Hepatitis A	☐	☐	Chickenpox	☐	☐
Hepatitis B	☐	☐	Tdap	☐	☐

Is your chid allergic to Any Medicine _____ any

Food _____

Anything Else _____

Does your child wear spectacles ? Yes ☐ No ☐ Does your child suffer from any kind of colour blindness ?

Parent's Remark/Suggestion _____

Date _____ Parent's Signature