STUDENT'S HEALTH RECORD

General Information

Name:	Admission No: .....
Date of Birth:	Father's Guardian's Name & Address:.....
	Phone No. Office: .....
	Residence : ..... Mobile: .....

BOTH SIDES OF THIS FORM TO BE SUBMITTED AT THE TIME OF ADMISSION

Name of the Student ..... M/F …….....Class.....

Date of Birth ..... Blood Group .....

Father's Name ……..... Mother's Name …….....

VACCINATIONS

Immunization	Age Recommended	Due Date	Date
BCG	0-1 Month		
Hepatitis B	At Birth		
	1 Month		
	6 Month		
DPT	2 Months		
	3 Months		
	4 Months		
HB	2 Months		
	3 Months		
	4 Months		
Oral Polio	At Births		
	1 Months		
	2 Months		
	3 Months		
	4 Months		
Measles	9 Months		
MMR	16 Months		
DPT+OPV+HIB	18 Months		
Typhoid	2 Years		
Hepatitis A (2 Doses)	2 Years		
Chicken Pox	After age 1 year		
DT – OPA	4½ Year		

BOOSTER DOSES

Typhoid (every 3 years)			
TT (every 5 years)			
Other Vaccines			

Signature of Father .....Signature of Mother .....

HEALTH HISTORY

ALLERGY TO ANY FOOD, ADHESIVE TAPE, BEE STING

Allergy	What Happened	How Severe	Medication Taken at the Time of Allergy

• Does the child have any problem during physical activity .....

Signature of Father ..... Signature of Mother.....

To be certified by a Registered Medical Practitioner

Date of physical examination..... Height ..... Weight.....

B.P..... Pulse ..... Vision L ..... R.....

Squint..... Conjunctiva..... Cornea..... Ear L..... R.....

Clinical Examination	Normal	Recommendation	
Head/Neck			
Abdomen			
Surgery			
Serious Illness			
Nails			
Skin			

Summary of Current Health Condition, _____

_____

_____

- Fit to Participate in age specific physical activity _____
- Fit to participate in age specific physical activity with precaution _____
  _____
- Should not participate in competitive sport _____

Signature of Doctor .....

Name of the Doctor.....

.....												
General Appearance												
Weight Kg. Actual Percentile												
Height Cms Actual Percentile												
Eye Vision R. E.												
L. E.												
Squint Conjunctiva Cornea												
Rt. Lt. Ears : External Ear Middle Ear												
ORAL CAVITY GUMS Colour Teeth Occlusion Caries TONSILS Lymph Nodes												
Pulse												
B.P.												
Nails												
Skin												
Muscle, Skeletal System Knee/Flat Feet/Lordosis/Kyphosis												
Systemic Examination												

Health Card

Name: _____Class_____

Age_____ Sex _____

Address:_____

Phone No: :_____

Blood Group:_____

The Major Parameters On Which The Annual Medical Checkups Done Are:

Dental _____

Eyes _____

General Cleanliness _____

Systemic Examination _____

Allergy (if any): _____

Date of Examination: _____

Past/Family History: _____

GENERAL:

Height: _____ Weight: _____

Nails: _____

Hair: _____

Skin:_____

Anemia: (Mild , Moderate, Severe or Absent)_____

Ear: _____

Nose: _____

Throat: _____

N ec k: ____ _____ _____ _____ _____ _____ _____ _____

DENTAL EXAMINATION:

i. Extra-oral_____

ii. Intra-oral

a) Tooth cavity_____ b) Plaque_____

c) Gum inflammation_____ d) Stains_____

e) Tarter_____ f) Bad breath_____

g) Gum bleeding_____ h) Soft tissue_____

SYSTEMIC EXAMINATION

Respiratory System: _____

Cardio vascular system _____

Abdomen: _____

Nervous System: _____

Eyes : _____

Right_____ Left_____

Important findings: _____

Remarks: _____

Medical officer's name and signature _____

Follow up : _____

_____

_____

Signature: _____ Date : _____

Designation: _____ Place : _____

Name: _____