



RHOMBUS WORLD SCHOOL, MEERUT

SCHOLAR NO:

Name Master/Miss	Father's Name Mr.	Mother's Name Mrs.
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MEDICAL HISTORY

(TO BE FILLED IN BY PARENTS/GUARDIAN)

1. Did the child have the following vaccinations(if yes, please mention date of vaccination):-

DPT	POLIO	BCG	MEASLES	TYPHOID	MMR	DT	ANY OTHER(SPECIFY)

2. Has the Child ever suffered from any of the diseases (Chicken Pox, Measles, German Measles, Small Pox, Mumps, Diphtheria, Whooping Cough, Enteric Fever, Rheumatic Fever)? If so, When?

3. Dose the child suffer from any functional or organic heart disease?

4. Has the child suffered from any severe respiratory conditions such as asthma, bronchitis, pneumonia, etc.? Is he/she prone to such ailments?

5. Has the Child ever had fits? If so, When and what was the diagnosis?

6. Has the child ever experienced urinary incontinence? If so, When? Is he/she is a bed is bed wetter? If so, for how long?

7. Are the child's teeth in good order? Any cavities, fillings, gum defects, etc.

8. Is child's hearing normal? Has he/she ever had discharge from ear?

9. Dose the child suffer from any physical deformity? e.g. flat feet, curvature of the spin, etc.

10. Is the child allergic to pollen, dust, food, drink, smells, Antibiotics, Sulpha drugs etc.?

11. Has he/she had any surgical operation in his/her like? If so given dates & details?

12. Dose he/she suffer from any other ailment, not referred to above? If so give details.

13. Is the child undergoing any medical treatment currently?

14. Are there any instructions, you wish to give to school administration in connection with your child? Please state them clearly. (Attach separate sheets, if necessary)

I hereby certify that I have given true & correct information in this form.

Date:

Signature of Parent:

MEDICAL FITNESS CERTIFICATE

(TO BE ISSUED BY A REGISTERED MEDICAL PRACTITIONER)

1. General Condition :				
2. Measurement:				
HEIGHT (in cms)	WEIGHT (in kgs)	ABDOMEN (in cms)	CHEST(EXPIRATION) (in cms)	CHEST(INSPIRATION) (in cms)
3. Blood Group :				
4. Vision:		Right Eye	Left Eye	
5. Examination of Ear Nose & Throat:				
6. Tonsils, adenoids or any Lymphadenopathy?				
7. Speech:				
8. Skin, Nails & Hair :				
9. Examination of Teeth & Gums:				
10. Bones & Joints:				
11. Respiratory System:				
12. Cardiovascular System:				
13 Gastrointestinal System :				
14. Genitourinary System:				
15. Any congenital Anomaly:				
16. Mark of Identification:				
17. Any other information/remarks:				

I hereby certify that I have thoroughly examined Mater/Miss.....Son/Daughter of Mr. and found him/her in good health and fit for school file and physical activities.

Signature of Doctor.....

Name.....

Qualifications.....

Medical Council Regn. No.....

Address.....

Date:.....