

THE SANSKAAR VALLEY SCHOOL

MEDICAL AND FITNESS CERTIFICATE



This is to certify that aged..... years
has been thoroughly examined by me for the following and I hereby certify the following:

- | | | |
|--|------------------------------|-----------------------------|
| 1. Allergies | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Asthma | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. Bleeding Disorder | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. Communicable Disease | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. Emotional Psychological Problems | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 6. Neurological Problems | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 7. Orthopedic Problem | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 8. Problems related to vision, hearing | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 9. Urinary Problems | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 10. Skin Problems | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 11. Stomach related problems | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 12. Any other medical/surgical illness | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

I also certify that he/she is fit to travel and to undertake the trip and activities as mentioned in the itinerary.

He /she is undergoing treatment /medication for

As follows

Signature of Medical Examiner Name

Seal and Regtn. No

Phone Number of Medical Practitioner in case of Emergency