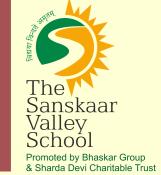
FOR OFFICIAL USE ONLY

(To be filled in by School Physician)

GENERAL EXAMINATION

Height:	cms	Weight:	Kgs
VNVISION			
Colour Blindness:		BP:	
Pulse:		Nails:	
Conjunctiva:			
SYSTEMIC EXAMINATION			
CNS:			
CVS:			
P/A:			
R/S:			
SUMMARY:			
Comments:			
Date:			Signature of Doctor



MEDICAL FORM

Personal Particulars

The Sanskaar Valley School, Chandanpura, Bhopal-462016. Ph.: +918889533346 - 49

Name of the Student:								
Class:S	ection:	Roll No.:						
Date of Birth:								
Name of Sibling if studying in scho ol:								
		Roll No.:						
Parental Details								
Parental Details								
Mother	Father							
Name :	Name	:						
Office Telephone:		phone:						
Email :	2111611	:						
Mobile No. :		:						
Residential Address:								
Residential Phone Number (s): ———								
Person apart from parent to be contacted in c	ase of emergency:							
Name :								
Relation :								
Address :								
Telephone: Office:	Residence:	Mobile:						
Family Physician:								
Name:								
Address (Clinic):								
Telephone: Clinic:	Residence:	Mobile:						

Email: -

MEDICAL HISTORY

Please read these instructions carefully filling up the Form.

- Each column should be filled bye the parent in consultation with the Medical Practitioner/ Family Physician.
- Please use the reverse side of the form for additional information, if necessary.
- No column should be left bank.

Health Record:

H <mark>ealth</mark> Problems	Details	Remarks if Any					
Allergies							
Asthma							
Neurological Problems							
Throat Infection							
Diabetes							
Frequent Ear Infections							
Hearing Difficulty							
Kidney/ Urinary Problem							
Orthopaedic / Bone Problems							
Skin Problems							
Eye Problems							
Glasses/ Contact Lenses							
Emotional/Psychological Problems							
Any Other							
Blood Group Rh Factor Dental							
a. Has your ward been recently checked	by a Dentist: Yes □ No □						
b. If yes, please furnish the details							
Recent or Past Illness							
a. Has your child suffered from any serious illness in the past: Yes □ No □							
b. If yes, give details including year, diagnosis & treatment							
Other Information							
Any other information relating to health of your ward, that you wish to indicate							

Immunization Record						
Type of Immunizations	Date Ist Dose	Date 2nd Dose	Date 3rd Dose	Date 4th Dose	Date 5thDose	
B.C.G.						
Diphtheria Pertussis Tetanus (D.P.T)						
Oral Polio						
Measles, R <mark>ebe</mark> lla (MMR)	4					
Mumps						
Typhoid						
Cholera						
Hepatitis, A [™]						
Hepatitis, B™						
Tetanus Toxoid						
Chickenpox						
HIB						
Any Other						
This is to certify that Master/ Miss Age						
is examined by me and has been found						
Signature of Medical Examiner			Signature of Pa	arent		
Name:			Name:			
Seal and Registration No:						