

3	Does / did he / she suffer from any ENT problems?		
	Frequent nosebleeds, Frequent colds, Frequent sore throat (tonsillitis), Symptoms of deafness, Tooth or Gum problems, Hay Fever, Any type of allergies		
4	Does / did he / she suffer from any Chest or Respiratory problems?		
	High Blood Pressure, Rheumatic Heart disease, Other Heart problems, Haemophilia (excessive bleeding)		
5	Does / did he / she suffer from any GI / GU conditions?		
	Abdominal pain, Appendicitis, Bladder / Urinary infection, Diarrhoea / Dysentery, Gall bladder, Frequent indigestion, Haemorrhoids, Kidney infection, Hernia		
6	Does / did he / she suffer from any skin conditions?		
	Scabies, Frequent boils, Eczema, Impetigo		
7	Does / did he / she suffer from any Neurological conditions ?		
	Dizziness / Fainting spells, Vertigo' Convulsions / Epilepsy / Fits, Neuritis, Frequent headaches		
8	Does / did he / she suffer from any other medical conditions ?		
	Mental illness, Depression, Hysteria, Psychiatric treatment, Insomnia, Sleep walking		
9	Has he / she had any surgical operation, head or other serious injury, or fracture of the bones? If so, please give particulars.		

10	Is he / she a bed-wetter ? If so, what is the frequency of occurrence ?		
11	Has he / she been X-rayed at any time ? If so, when and for what ?		
12	Are his / her eyes and eyesight normal ?		
13	Does he / she wear glasses or contact lenses (if yes, attach prescription) or suffer from any other eye ailment ?		
14	Are his / her teeth generally in good order ?		
15	Does he / she need any orthodontic treatment ?		

NOTES

MEDICAL HISTORY FORM (Part II)

Height	Cms.	Weight	Kgs.	Temp.	Pulse	B.P.
Chest (full expiration)				Chest (full inspiration)		
Blood group and RH				Blood & WBC Hgb-grams %		
Montoux Test (if done) -				Positive / Negative		
Pathology (blood, urine & stool, if applicable)						
Skin condition						
Eyes/Vision (attach prescription for glasses or lenses)						
Ears / Hearing						
State of appendages / extremities						
State of Spine & Neck, Posture						
Signs of flat feet or other defects						
Breasts						
Glands						
Throat / Tonsils						
Piles / Fissure						
Abdomen / Hernia / Spleen						
Pelvo - Rectal						
Cardin Vascular System						
Respiratory System						
Neurological / Central Nervous System						

Immunisation Record	Primary (DD, MM, YY)	Booster (DD,MM,YY)
BCG		
POLIO		
DPT		
MEASLES		
MMR		
TETANUS TOXOID		
TABC		
TYPHOID		
HEPATITIS 'A'		
HEPATITIS 'B'		
OTHERS		

This is to certify that I have conducted a thorough medical examination of _____
and that he / she is in a fit state of physical and mental health to join a residential school and does not suffer from
any infectious disease. He / she (tick one) is is not permitted to participate in games and
physical education activities.

Remarks / Restrictions

The above stated information is true and correct.

Signature of parent / guardian _____

Date: _____

Signature & stamp of Medical Practitioner

Regd No. _____

Name of Medical Practitioner _____

Address _____

Contact No. (Off.) _____ Contact No. (Res) _____