

## MEDICAL FORM

(Use block letters only. Please provide all information without leaving any blanks)

Enrolment Number:									
First Name:	Middle Name:			Last Name:					
Date of Birth: DD / MM / YYYY	Class:			Age:					
Gender: Male <input type="checkbox"/>	Female <input type="checkbox"/>			Blood Group:					
Power (in case of spectacles):	L/E:	R/E:	Weight (kgs):	Height (cm):					

## MEDICAL HISTORY

(Please give the details of any serious illness(es)/operation(s), contagious/infectious disease(s), your child might have suffered/undergone)

1) Diseases suffered, such as Measles, Mumps, Chicken Pox, Jaundice, Tuberculosis, Epilepsy, Swine Flu (H1N1) etc.

SR. NO.	DISEASE	YEAR

2) Operation(s) undergone, such as Appendicitis, Fracture etc.

SR. NO.	DISEASE	YEAR



## MEDICAL HISTORY

Allergy (if allergic to any drug or food):

### Details of Vaccination (please attach a photocopy of the vaccination card)

NAME	1ST DOSE	2ND DOSE	3RD DOSE	BOOSTER
BCG				
DPT/OPV				
MMR				
Typhoid				
Hepatitis A				
Hepatitis B				
Chicken Pox				

### Declaration (if due vaccinations are not given):

I/We hereby  give/  do not give/  shall write back in 10 days, my consent for vaccination of my child for  (i) Typhoid  (ii) Chicken Pox  (i) Hepatitis A  (iv) Hepatitis B  (v) Any other Vaccine.

(Tick whichever is not applicable)

Place:

Date:

\_\_\_\_\_  
Parent/Legal Guardian's Name (in capital letters)

\_\_\_\_\_  
Signature of Parent/Legal Guardian