Uttan Vividh Lakshyi Shikshan Santha's

Ram Ratna Vidya Mandir

ISO 9001:2000 Certified School ♦ CBSE Affiliation No.1130044

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We shape global minds, Indian souls

HEALTH CERTIFICATE

Name of the Student : ______________________________

Father's name : ______________________________

Standard : ______________

G.R. No. : ______________ Hostel: ______________ House: ______________

Address : ______________________________

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Phone No. : (R)______________ (M)______________

Medical Check up by Physician

1. **Has the student suffered from any of the following?**

i) Asthma : Yes / No, if yes, please specify ______________

______________ Medicine ______________

ii) Allergy to Medicine : Yes / No, if yes, please specify ______________

______________ Medicine ______________

iii) Allergy to food : Yes / No, if yes, please specify ______________

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iv) Bed Wetting : Yes / No

v) Any Operation : Yes / No, If yes, please specify______________

______________ Medicine ______________

vi) Epilepsy or Convulsion : Yes / No ______________ Medicine ______________

vii) Nose Bleeding : ______________________________

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viii) Any Blood disorder : ______________________________

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ix) Diabetes : ______________________________

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x) Fast Pulse or Heart Disease: ______________________________

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xi) Heart : ______________________

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xii) Lungs : ______________________

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xiii) Ear, Nose, Throat : ______________________

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xiv) Liver : ______________________

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xv) Skin disease : ______________________

(Ring Worm, Scabies etc) ______________________

2. <u>Pathology Report by qualified Pathologist</u>

vi) Urine Test

(i) Routine : ______________________

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(ii) Microscopic : ______________________

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vii) Stool Test for cyst & ova : ______________________

viii) Complete Haemogram : ______________________

ix) Blood Grouping : ______________________

x) Mantoux Test : ______________________

xi) Australia Antigen : ______________________

xii) G_6PD : ______________________

xiii) X-ray Chest : ______________________

(Sr.No. 1 & 2, Checkup & Report by the concerned doctor should be sent along with the student)

3. Is there any physical abnormality or any other habit that needs special attention? Give details of the treatment to what he responds? ______________________

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4. Any other disease (which is not mentioned above) ______________________

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5. **Vaccination:** Vaccination of Typhoid, Hepatitis, Tetanus must be given before the student is sent to school. (Doctor's report of vaccination given should be sent along with the student)

Signature with date ____________________________

Name of the Doctor ____________________________

Registration No. ______________________________

6. **Eye Check-up:** Testing of eyes and report by Ophthalmologist/Eye Surgeon should be sent along with the student.

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(Students wearing spectacles are requested to bring the concerned doctor's prescription / address and two sets of spectacles)

Signature with date ____________________________

Name of the Doctor ____________________________

Registration No. ______________________________

7. **Dental Check-up:** Dental Check-up & report by a Dentist should be sent along with the student.

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(Students wearing orthodontic appliances should bring the concerned doctor's prescription / address and instructions for readjustment etc.)

Signature with date ____________________________

Name of the Doctor ____________________________

Registration No. ______________________________

My Family Doctor ______________________(Tel.)__________________(Mob.)________________________ Sign __________________

Any other information or the name & address of the person to be contacted in emergency

Address:____

____

____

Tel. No. (Res)__________________________(Off)_________________________________(M)__________________________________

I hereby declare that all the above checkup and report has been done by the concerned doctor.

Note: Please attach your family Doctor's Consent papers.

__________________________ __________________________

(Sign of Student) **(Sign of Parents)**

Medical Certificate

(This Medical Certificate should be filled & signed by Registered Medical Practisner / Family Physician)

Certified that I have carefully examined Master ________________________________ _______ S/o. Mr. ____ Age ______________yrs. and find him physically and mentally fit in all respects to undertake the strenuous routine of Residential School life.

Height	:	________________ *cms.*
Weight	:	________________ *kg.*
Chest Measurements	:	________________ *cms.*
Vision: with/without glasses	:	______________________
Hearing	:	______________________
Blood group of the child	:	______________________
Past history of operation or illness	:	______________________

I further certify that there is nothing adverse in his medical history (e.g. Asthama, Epilepsy, Severe Allergy) which may later incapacitate him from continuing his education. Master____ has been fully protected in childhood with BCG, Polio, DPT and Measles Vaccine.

In emergency the school authority can contact me on the below mentioned address/Tel. No.

Signature with Date ____________________

Name of the Doctor ____________________

Reg. No. ____________________________

Address ____________________________

____

Tel. No. ____________________________

Mobile _____________________________

DECLARATION

I declare that the attached information about my son's medical history is true to the best of my knowledge. I do understand that concealing any vital information about his health may mislead the school doctors and this may prove dangerous for my son's health.

I also understand that while in the school campus, if my son needs medical attention, he will be attended by the school medical staff and if required the treatment will be started immediately. If immediate hospitalization is required for any reason, he will be admitted in the school's mini hospital or appropriate nearby hospital. I hereby give my full consent for the same.

In case of long term ailments / contagious or infectious disease, it will not be possible for the school to keep the child in the campus, whenever notified, I will make immediate arrangements to take my son home.

The expenses incurred for the investigations and treatment of my son will be fully borne by me.

In case he is found unsuitable medically his admission would be cancelled.

Place :   Signature of Parent ___________________________

Date :   Name of the Parent ___________________________