



UTTAN VIVIDH LAKSHYI SHIKSHAN SANSTHA'S

RAM RATNA VIDYA MANDIR

ISO 9001:2000 CERTIFIED SCHOOL CBSE AFFILIATION NO. 1130044

Keshav Srushti, Uttan, Bhayander (W), Thane: 401106, Maharashtra, India.

Tel.: 0091-22-2845 0707/ 2845 0718, Fax: 0091-22-2845 0500

Website: www.ramratnavidyamandir.org Email: doctors@ramratnavidyamandir.org, principal@ramratnavidyamandir.org

HEALTH CERTIFICATE

Name of the Student : _____
Father's name : _____
Standard : _____
G.R. No. : _____ Hostel: _____ House: _____
Address : _____
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 _____
- 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 : _____
- viii) Any Blood disorder : _____
- ix) Diabetes : _____
- x) Fast Pulse or Heart Disease: _____
- xi) Heart : _____
- xii) Lungs : _____
- xiii) Ear, Nose, Throat : _____
- xiv) Liver : _____
- xv) Skin disease : _____
(Ring Worm, Scabies etc)

2. Pathology Report by qualified Pathologist

- vi) Urine Test
(i) Routine : _____
- (ii) Microscopic : _____
- vii) Stool Test for cyst & ova _____

- viii) Complete Haemogram _____
- ix) Blood Grouping _____
- x) Mantoux Test _____
- xi) Australia Antigen _____
- xii) G₆PD _____
- 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?** _____

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

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.

(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.

(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 Practitioner / 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 _____