

RAM RATNA VIDYA MANDIR

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ISO 9001:2000 CERTIFIED



CBSE AFFILIATION NO. 1130044

MEDICAL DEPARTMENT

MEDICAL HISTORY OF THE CHILD

(TO BE SUBMITTED AT THE TIME OF REGISTRATION)

1. Name of the child : _____
2. Date of Birth : _____
3. Height in cms : _____
4. Weight in Kgs : _____
5. Has the child been given all the vaccinations ? Yes / No
Xerox copy of vaccination record, may please be submitted.

6. Family history of illness –

| | Father | Mother | Elder Brother/Sister |
|----------------|--------|--------|----------------------|
| Diabetes | _____ | _____ | _____ |
| Blood Pressure | _____ | _____ | _____ |

5. Past history of major illness :-
 - (a) Was the child admitted to hospital at any time : Yes /No
If yes :
For what :
How long :
Please submit treatment record.
 - (b) H/O Bed Wetting : _____
 - (c) H/O Tumb sucking : _____
 - (d) H/o Anti acid Activity : _____
 - (e) H/O Drug Allergy : _____

6. History of Psychiatric Problem :
 - (a) Is the child too much dependant on parents ?

 - (b) Mention behavioural problems if any :

Food Habits :

- Is he taking plain milk regularly. Yes / No
- Does he take curd ? Yes / No
- Is he taking all vegetables. Yes / No
- Any difficulty in eating habits, Please mention :

Signature of the Parent :

Name of Father : _____

Name of Mother : _____