



Uttan Vividh Lakshyi Shikshan Santha's

Ram Ratna Vidya Mandir

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

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Indian souls

MEDICAL DEPARTMENT

MEDICAL HISTORY OF THE CHILD

(To be submitted at the time of registration)

- Name of the child : _____
- Date of Birth : _____
- Height in cms : _____
- Weight in Kgs : _____
- 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 : _____

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