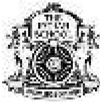
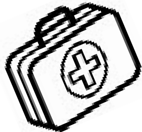




THE INDIAN SCHOOL

Medical Record Updation
2025-26

Dear Parents

Kindly provide the following information in regard to your ward's medical record.

Name of the child: ______________________________________

Class and section: _______________

Blood Group: __________________

Father's Name, Phone No. & Mobile No: ____

Mother's Name, Phone No. & Mobile No: ____

Local Guardian's Name, Phone No. & Mobile No: ____________________________________

Emergency Phone No.: __________________________

History of illness:

i.	Asthma	Yes/No
ii.	High Blood Pressure	Yes/No
iii.	Diabetes	Yes/No
iv.	Heart Disease	Yes/No
v.	Kidney Problem	Yes/No
vi.	Bleeding through Nose	Yes/No
vii.	Fits	Yes/No
viii.	Any other disease	Yes/No, if yes, please give details.

____

ix. Has your ward undergone a surgical procedure? If yes, please give details.

____

x. Is your child on any medication? If yes, please give details.

____

xi. Has your ward suffered from any major illness? If yes, please give details.

____

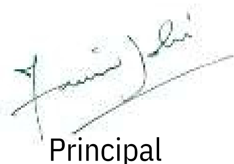
xii. Is your child allergic to any medication? If yes, please name medication.

____

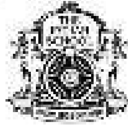
Kindly submit this form duly filled to the class teacher on the book submission day, March 2025

Signature of Father: ....   Signature of Mother: ....

Date: ....

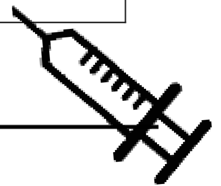


Principal



THE INDIAN SCHOOL

Immunization	Age Recommended	Due Date	Date
BCG	0-1 Month		
Hepatitis B	At Birth		
	1 Month		
	6 Months		
DPT	2 Months		
	3 Months		
	4 Months		
HB	2 Months		
	3 Months		
	4 Months		
Oral Polio	At Birth		
	1 Month		
	2 Months		
	3 Months		
	4 Months		
Measles	9 Months		
MMR	16 Months		
DPT + OPV+HIB	18 Months		
Typhoid	2 Years		
Hepatitis A (2 Doses)	2 Years		
Chicken Pox	After age 1 year		
DT-OPA	4 ½ year		

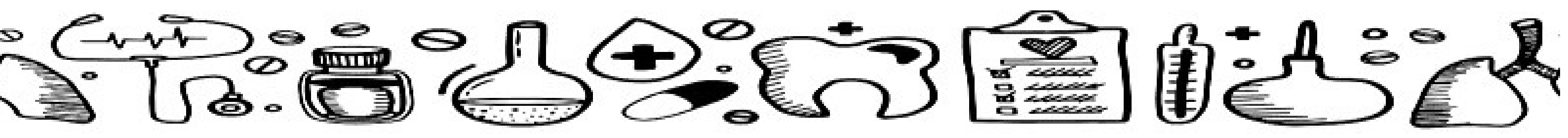


BOOSTER DOSES

Typhoid (Every 3 years)			
TT (Every 5 years)			
Other Vaccines			

Signature of Father .... Signature of Mother.........................

Josip Broz Tito Marg (Near Moolchand Flyover) New Delhi 110049
Phone: 26257551, 26257552, 26265956, 26265957, Fax: 26253185
E-mail: contactus@theindianschool.in Website: www.theindianschool.in



HEALTH HISTORY

ALLERGY TO ANY FOOD, ADHESIVE TAPE, BEE STING

Allergy	Reaction	How Severe	Medication Taken at the Time of Allergy

- Does the child have any problem during physical activity ....

Signature of Father .... Signature of Mother ....

To be certified by a Registered Medical Practitioner

Date of Physical Examination .... Height .... Weight ....

B.P .... Pulse .... Vision L .... R................

Squint .... Conjunctiva .... Cornea .... Ear L .... R ....

Clinical Examination	Normal	Recommendation	
Head/Neck			
Abdomen			
Surgery			
Serious Illness			
Nails			
Skin			

Summary of Current Health Condition ____

____

- Fit to participate in age specific physical activity ___________________________________
- Fit to participate in age specific physical activity with precaution ____________________
- Should not participate in competitive sport ____

Signature of Doctor ....