THE INDIAN SCHOOL- SECOND SHIFT

Medical Record Updation

2025-26

Dear Parents

Kindly provide the following information in regards 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 submission day, March 2025

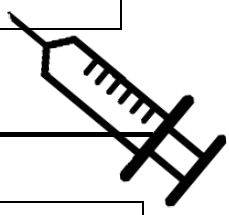
Signature of Father: ……..……..…….. Signature of Mother: ……

Date: ……

Principal

THE INDIAN SCHOOL- SECOND SHIFT

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……..……

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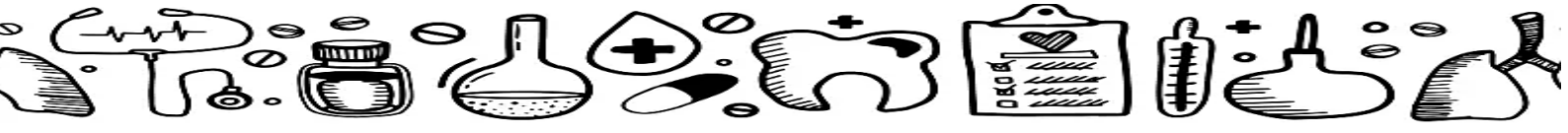

HEALTH HISTORY

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 …….