THE INDIAN SCHOOL

MEDICAL RECORD UPDATION (2026–27)

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

STUDENT INFORMATION

Full Name:	Class & Section:
Blood Group:	Emergency Contact No:
Father's Name:	Father's Contact No.
Mother's Name	Mother's Contact No.

MEDICAL HISTORY

1. Asthma ☐ Yes ☐ No
2. High Blood Pressure ☐ Yes ☐ No
3. Diabetes ☐ Yes ☐ No
4. Heart Disease ☐ Yes ☐ No
5. Kidney Problem ☐ Yes ☐ No
6. Bleeding through Nose ☐ Yes ☐ No
7. Fits ☐ Yes ☐ No
8. Any other disease ☐ Yes ☐ No
   If yes, please give details:

9. Has your ward undergone any surgical procedure? ☐ Yes ☐ No
   If yes, please give details:

10. Is your child on any medication? ☐ Yes ☐ No
    If yes, please give details:

11. Has your ward suffered from any major illness? ☐ Yes ☐ No
    If yes, please give details:

12. Is your child allergic to any medication? ☐ Yes ☐ No
    If yes, please name the medication:

Signature of Father: _____ Signature of Mother: _____

Date: _____

Principal

THE INDIAN SCHOOL

IMMUNIZATION RECORD

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 Months		
	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 1 Year		
DT-OPA	4½ Years		

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? ☐ Yes ☐ No
If yes share the details

_____

Signature of Father: _____ Signature of Mother: _____

To be certified by a Registered Medical Practitioner

Date of Physical Examination: _____Height: _____ Weight: _____
BP: _____Pulse: _____Vision: Left _____ Right _____
Squint: _____Conjunctiva: _____Cornea: _____Ear: Left _____ Right _____

CLINICAL EXAMINATION

Area	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 with precaution
- ☐ Should not participate in competitive sport

Signature of Doctor: _____