



# THE INDIAN SCHOOL-SECOND SHIFT

## 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:

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9. Has your ward undergone any surgical procedure?  Yes  No

If yes, please give details:

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10. Is your child on any medication?  Yes  No

If yes, please give details:

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11. Has your ward suffered from any major illness?  Yes  No

If yes, please give details:

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12. Is your child allergic to any medication?  Yes  No

If yes, please name the medication:

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Signature of Father: \_\_\_\_\_

Signature of Mother: \_\_\_\_\_

Date: \_\_\_\_\_

Principal



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## 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

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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: \_\_\_\_\_

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

Signature of Doctor: \_\_\_\_\_