THE INDIAN SCHOOL

Medical Record Updation 2023-24

Dear Parents

Kindly provide the following information of your ward's medical record.

Name of the child: _____

Class and section: _____

Blood Group: _____

Father'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 the dully filled form to the class teacher on the submission day, 29th March 2023

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

Date: ……

Mrs. Tania Joshi

Principal

THE INDIAN SCHOOL

Name of the Student ……M/F……Class…….

Date of Birth ……. Blood Group…….

Father's Name …… Mother's Name……

VACCINATIONS

Immunization	Age Recommended	Due Date	Date
BCG	0-1 Month		
Hepatitis B	At Birth		
	1 Month		
	6 Month		
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	What Happened	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 ……

Name of the Doctor