MEDICAL FORM

(To be filled by the Family Doctor)

I . Name of the student : [ ]

2. Date of Birth : [ ][ ][ ][ ][ ][ ][ ][ ]

3. a)Height ______________________________ (b) Weight____________________ (c) Chest ______________________

4, Identification Marks (i) ______________________________
(ii)____

5. a) Last Inoculation taken on :____

b) Last/vaccination taken on : ____

6. Record after each disease given below with (0) for positive and (-) for negative, depending

whether the boy/girl has suffered from it or not : ____

i) Fever [ ]	ii) Malaria [ ]	iii) Typhoid [ ]	iv) Enuresis [ ]
v) Measles [ ]	vi) Nephritis [ ]	vii) Diphtheria [ ]	Viii) Mental retardation [ ]
Ix) Worms [ ]	x) Poliornyelities [ ]	xi) Asthma [ ]	xii) Dysentery [ ]

7. Other information

I) Eyes : Refractive Error / Trachoma

ii) Ears Any discharge / disease/ deafness

iii) Nose : Epistaxis - D.V.S.

iv) Tonsils : Chronic Enlargement

v) 0.1.1. - Appendicular Colic

Any other Colic

vi) Hemia / Hydrocele

vii) Phimosis

8. Any injury, illness or operation during the last two years .

9. Allergy to drugs : Penicillin group, Quinine, Chloramphenlco, ferramycin and any other drugs.

10. BOG ____

11. Small Pox : ____

12. Blood Group [ ]

Name of the doctor ____

Address : ____

Doctor Mob. No. : ____

Counter Signature **Signature of the Doctor**