

Student Health Record

GENERAL INFORMATION

Name of the Student: Gender: Boy / Girl

Paste Student's
recent passport size
photograph here.

Date of Birth: Blood Group: Age :

Mother's Name :

Father's Name / Guardian's Name :

Address :

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Phone No. : Off. Res. Mob.

VACCINATIONS

Immunization	Age Recommended	Received	
		Yes	No
BCG	0-1 Month		
Hepatitis B (HEP-B)	At Birth		
	1 Month		
	6 Months		
DPT	2 Months		
	3 Months		
	4 Months		
Oral Polio	At Birth		
	1 Month		
	2 Months		
	3 Months		
	4 Months		
Measles	9 Months		
Chicken Pox	After age 1 year		
MMR	16 Months		
DPT + OPV + HEP-B	18 Months		
Typhoid	2 Years		
Hepatitis A (2 Doses)	2 Years		
Typhoid	Every 3 years		
	Every 5 years		
Other vaccines			

BOOSTER DOSES:

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Name of the Doctor

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Signature of the Doctor
with seal

HEALTH HISTORY

(To be filled by the Parents)

1. Did the child suffer from any specific ailment in the past ? If yes, specify.

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2. Did the child undergo any operation in the past ? If yes, specify.

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3. Does the child suffer from any allergy? If yes, specify.

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4. Is the child on any regular medication? If yes, specify.

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5. Does the child have any problem during physical activity? If yes, specify.

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Signature of the Mother.....Signature of the Father

TO BE CERTIFIED BY A QUALIFIED & REGISTERED MEDICAL PRACTITIONER

Date of physical examination : Height : cms Weight Kgs

B.P. : Pulse : Vision : L..... R Squint :

Conjunctiva : Cornea : Ear : L R

Dental Hygiene:

Clinical Examination	Normal	Recommendation
Head / Neck		
Abdomen		
Surgery		
Serious Illness		
Nails		
Skin		

Summary of current health condition

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Please Tick () any one whichever is applicable:

Fit to participate in age specific physical activity.

: ☐

Fit to Participate in age specific physical activity with precaution. :

☐

Should not participate in competitive sports.

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Name of the Doctor

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Signature of the Doctor
with seal