



HEALTH INFORMATION AT ADMISSION

Name of the Child : _____ Class & Sec : _____ D.O.B. : _____

Father's Name : _____ Admission No. : _____

Tel (Mobile) _____ (Off.) _____ (Resi.) _____

Mother's Name : _____

Tel (Mobile) _____ (Off.) _____ (Resi.) _____

Blood Group : _____

I Vaccinations (With Date)

- i) BCG (0-3 m) _____
- ii) DPT (1½ m) _____ (2½ m) _____ (3½ m) _____ (1½ yrs.) _____ (4½-5) yrs. _____
- iii) Polio (Birth) _____ (1½ m) _____ (2½ m) _____ (3½ m) _____ (4½ m) _____
- iv) Hepatitis B (Birth) _____ (1 m) _____ (6 m) _____ (5 yrs.) _____
- v) Hepatitis A (1 yr.) _____ (1½ yrs.) _____
- vi) Hib (1½ m) _____ (2½ m) _____ (3½ m) _____ (15 - 18)m _____
- vii) Measles (9 m) _____
- viii) Chickenpox (Birth) _____
- ix) MMR (12 - 15) m _____
- x) Typhoid (2 yrs.) _____ (5 yrs.) _____ (8 yrs.) _____ (11 yrs.) _____
- xi) Tetanus Toxid (10 yrs.) _____ (15 yrs.) _____
- xii) Any other _____

II DISEASE IN PAST

- Asthma
- Rheumatic Heart Disease
- Epilepsy
- Any Other

III FAMILY HISTORY (Diabetes, Hypertension etc.)

IV ALLERGIES

- Food
- Contact with skin
- Drugs
- Any other

V PRESENT MEDICATION IF ANY :

VI ADDITIONAL INFORMATION :

PARENT'S SIGNATURE

SCHOOL DOCTOR'S REMARKS

DOCTOR'S SIGNATURE