TAGORE INTERNATIONAL PUBLIC SCHOOL

Sangam Vihar Wazirabad,Delhi-84

MEDICAL INFORMATION FORM – STUDENTS

1. Student’s Name…………… Class&Sec…..Blood Group ………Bus Route

2. Residential Address …………………………………………………………………………………………..

3. Family Doctor’s Name……………………………………… Contact No ….……

4. Major vaccination given as per schedule – give details Yes/No

5. Any family history of major illness

If yes, please give details separately.

6. Has the students suffered from:-

a. Any major illness in the past one year Yes/No

If yes, please give details

b. Does the student suffer from any Food/medicine/pollen allergies Yes/No

If yes, please give details

c. Does she take any medicine Regularly Yes/No

If yes, please give details

d. Any chronic illness (Diabetes, Epilepsy, Asthma,.Migraine etc.) Yes/No

If yes, give details.

e Any communicable desease (T.B, Asthma,. etc.) Yes/No

If yes, give details.

7. School care as requested by parents

Signature of Mother ………………………… Date ……………….

Contact No. ………………………………………

Signature of Father ………………………….. Contact No :……………...

Signature of Mother ………………………….. Contact No :……………...

(In case of emergency, Name , Telephone No. of the Person to be contacted.)

Contact Person

Name ,……………………………. Telephone No. ……………………………….

Address with Landmark :……………………………………………………………………………..………….

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VACCICATION-DETAIL

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 Given |
|  | 0-1 Month | Hapatitis B At Birth |  |  |
|  | 1 Month | 6 Month |  |  |
|  | DPT 2 Months | 3 Months |  |  |
|  | 4 Months | HB 2 Months |  |  |
|  | 3 Months | 4 Months |  |  |
|  | Oral Polio At Births | 1 Months |  |  |
|  | 2 Months | 3 Months |  |  |
|  | 4 Months | Measles 9 Months |  |  |
|  | MMR - 2- The second dose of MMR vaccine can  be given at any time 8 weeks after the  first dose |  |  |  |
| DPT+OPV+HIB | 18 Months |  |  |  |
| Typhoid | 2 Years |  |  |  |
| Hepatitis A ( | 2 Doses) 2 Years |  |  |  |
| Chicken Pox | Age less than 13 years  One dose  Age more than 13 years:  2 doses at 4-8 weeks interval |  |  |  |
| DT – OPA | :4½Year |  |  |  |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Booster\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Typhoid (every 3 years) |  |  |  |
| TT (every 5 years) |  |  |  |
| Other Vaccines  1.Rotational Vaccines  2.Pneumococcal Conjugate  3.HPV | 1.More than 6 weeks: 2/3 doses (Depending on Brand) at 4-8 weeks interval  2.More than 6 weeks : 3 primary doses at 6,10 and 14 weeks followed by a booster at  15-18 months.  3.10 years : only girls, three doses at 0,1-2 and 6 months | | |

HEALTH-HISTORY

ALLERGY TO ANY FOOD, ADHESIVE,TAPE, BEE STING

|  |  |  |  |
| --- | --- | --- | --- |
| Allergy | What Happened | How Severe | Medication Time Of Allergy |
|  |  |  |  |

Does the child have any problem during physical activity ?……………………………………………...

To be certified by a Registered Medical Practitioner

Name of the student ………………………………………………… class ………………………….. Sec ………………….

Signature of Father …………………………Signature of Mother …………………………………………..

Date of Physical examination ……………Height…………………………….Weight…………………..

B.P …………………….………Pulses ………………………………… Vision L …………………….. R …………………………..

Squint ……………………… . Conjunctiva ……………………Cornea ………………Ear L…………R ………..

|  |  |  |  |
| --- | --- | --- | --- |
| Clinical Examination | Normal | Recommendation |  |
| Head/ Neck |  |  |  |
| Abdomen |  |  |  |
| Surgery |  |  |  |
| Serious Illness |  |  |  |
| 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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the doctor………………………… Signature of doctor

With Regn No

Thought for success: Success is a Delicious Dish. Patience, Intelligence, Talent and Ability are Key Ingredients. But Hard Work is that Little Salt that makes it Tasty.