

# MEDICAL FORM

CLASS : \_\_\_\_\_

Name of the child in full : \_\_\_\_\_ Gender : Male / Female

Date of Birth : \_\_\_\_\_ Place of Birth : \_\_\_\_\_  
Date Month Year

Religion : \_\_\_\_\_

Residential Address : \_\_\_\_\_

City : \_\_\_\_\_ State: \_\_\_\_\_ Pincode : \_\_\_\_\_ Tel No. (Resi.) \_\_\_\_\_

Number of siblings  : Name \_\_\_\_\_ Age \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_

Number of members living at home  : \_\_\_\_\_

and their relationship with the child. : \_\_\_\_\_

: \_\_\_\_\_

## TO BE FILLED BY THE DOCTOR

### Vaccines given : (TICK whichever is applicable)

<input type="checkbox"/>	B.C.G.	<input type="checkbox"/>	MEASLES	<input type="checkbox"/>	CHICKEN POX
<input type="checkbox"/>	OPV. DPT	<input type="checkbox"/>	HEPATITIS-A	<input type="checkbox"/>	MMR
<input type="checkbox"/>	1st BOOSTER	<input type="checkbox"/>	HEPATITIS-B	<input type="checkbox"/>	OTHERS
<input type="checkbox"/>	2nd BOOSTER	<input type="checkbox"/>	T.T		

1. Blood Group \_\_\_\_\_

2. Weight in Kg. \_\_\_\_\_

3. Height in Cm. \_\_\_\_\_

4. ENT\* \_\_\_\_\_

5. Skin \_\_\_\_\_

6. Respiratory System \_\_\_\_\_

7. Chronic Illness (if any) \_\_\_\_\_

8. Surgery Details (if any) \_\_\_\_\_

## HEALTH & MEDICAL HISTORY

1. Past significant illness :

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2. Current health-related complaints or illness :

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3. Treatment received for current ailment (if any) :

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4. Date of last physical examination and result\*

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5. Name of the physician and contact number :

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6. Significant health problems in the family of origin (parent, grandparents, siblings)

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7. Sleep pattern :

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8. Appetite level :

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9. Current medication (if any) :

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10. Does the child require regular medical assistance. If yes. specify.\*

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11. Drug and non-drug allergies :

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12. Daily diet habits :

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\* Please attach relevant documents.

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Doctor's Signature & Stamp