आचार्यकुलम् शिक्षा संस्कारः अभ्युदयः निश्रेयसः Acharyakulam

Student Health Record

For Office use only
Admn. No. .....
Class & Section .....

Name of the Student:..... Gender: .....

Paste Student's recent passport size photograph here

Date of Birth: ..... Blood Group: ..... Age :.....

Mother's Name : .....

Father's Name / Guardian's Name : .....

Address : .....

.....

.....

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		
DPT - OPV	4½ Years		
T.T.	Every 5 years		
COVID vaccine			

BOOSTER DOSES:

.....
Name of the Doctor

.....
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 .....

.....

Please Tick (✓) <u>any one</u> 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

Signature of the Doctor with seal