KAMAL PRATISHTHAN
Mount Litera
Zee School
Great School. Great Future

Health Information Form

To Be completed by Examining Physician Section –A

Name: ____Date of Exam: _________________

Height: _____________________Weight______________________Blood Group: _______________

Examination:

		Normal	Abnormal	Notes
1	Eyes			
2	Nose			
3	Throat			
4	ENT			
5	Ears			
6	Skin			
7	Teeth			
8	Oral Hygiene			
9	Lymph Nodes			
10	Nails/skin			
11	Tonsils			
12	Bones & Joints			
13	P/A			
14	R/S			
15	CVS			
16	CNS			

Student’s Immunization Record

An accurate immunization history is required to determine whether your child is adequately protected against major preventable childhood diseases. Please fill the area below carefully, supplying details.

Vaccine	Status
Polio(TOPV)Tri-oral polio vaccine	
DPT Diptheria,tetanus & pertussis, OR	
TD Diphtheria/tetanus	
Measles	
DPT/OPV Boosters	
BCG	
Typhoid Meningitis HIB	
HIB Booster	
Hepatitis B	
Hepatitis –A	
Chicken Pox	
MMR	
Comments	

EMERGENCY PERMISSION

	YES	NO
I grant permission for the appointed person to administer non- prescribed medications as Crocin, Paracetamol, Throat, lozenges, etc.		
I grant permission to obtain appropriate medical help for the student in an emergency if, after extensive efforts, parents cannot be contacted.		
I hereby, give permission for emergency measures to be initiated in case of accident or sudden illness with the understanding that I will be intimated as soon as possible.		
I understand that I, as the parent, I am solely responsible for all hospital, doctors and medical bills.		

Signature of Parents/Guardian.

Father	Mother	Date