SSA-1

SAINIK SCHOOL AMARAVATHINAGAR

Health Information Form

(To be completed by Doctor minimum MBBS Qualified and deposited to the school before admission medical test)

Date: _____ Section – "A" No: _____

- Name of Boy: _____

_____

- Height :_____ Weight:_____ Pulse:_____ Blood Pressure:_____
- Examination: Blood Group:_____ Hb%:_____

Sl. No	Particular to Check	Normal	Abnormal	Remarks
1.	Eyes (Vision Test)			
2.	Throat			
3.	Ears			
4	Skin			
5.	Lymph Nodes			
6.	Oral Hygiene			
7.	Teeth			
8.	Tonsils			
9.	Nails/Skin			
10.	Nose			
11.	ENT			
12.	P/A			
13.	R/S			
14.	CVS			
15.	CNS			
16.	Bones & Joints			

RECOMMENDATIONS BY THE DOCTOR

- Competitive Sports: Yes ☐ No ☐
- Physical Education: Yes ☐ No ☐
- Are there any limitations on Physical activities: Yes ☐ No ☐

  If yes, please specify _____
- Dietary Restrictions/Allergies: _____
- Special Precautions to be taken: _____

Sl. No	Immunisation Record	At Age	Yes/No	Remarks
1.	BCG			
2.	Polio (Tri Oral Polio Vaccine)			
3.	DPT			
4.	Measles			
5.	MMR			
6.	Tetanus Toxoid			
7.	Typhoid			
8.	Hepatitis 'A'			
9.	Hepatitis 'B"			
10.	Chicken Pox			
11.	DPT/OPV Boosters			
12.	Meningitis HIB			
13.	HIB Booster			

- This is to certify that I have conducted a thorough medical examination of Master. _____ and find that he is in a fit state of physical & Mental health & does not suffer from any infectious disease. He is permitted/not permitted to participate in games & physical activities.

Date: _____ _____

Signature & Stamp of Medical Practitioner

- Regd. No.: _____
- Name of Doctor: _____
- Address: _____
- Contact No.(Off.) : _____ (Resi.) _____ Mob. : _____

Name of child:_____ Roll No:_____

Section – "B"

(To be filled by Parents)

- Child's Name: _____ Date of Birth: _____
- Family Doctor's Name: _____ Tel. No. : Clinic: _____ Mob. :_____
- Emergency Ph. No.: Father:_____ Mother :_____Local Guardian : _____
- Student Health History:

Does your child have any of the following: If yes, please give details

Sl. No.	Particulars	Yes	No	Details
1.	Asthma			
2.	Congenital Health Problem			
3.	Seizure Disorder/Epilepsy			
4.	Diabetes			
5.	Recurring Ear Infections			
6.	Hearing difficulties			
7.	Frequent Headaches			
8.	Heart Problem			
9	Kidney/Urinary Problems			
10	Orthopedic			
11	Skin Problems			
12.	Glasses/Contact Lenses			
13.	Other known medical condition			
14.	Past history of any allergies			
15	Speech problem			

- Please explain if your child is visiting a psychologist or has any behavioral problem:_____

_____

- Does your child have any learning disabilities? Please specify:_____

_____

- Has your ward had any of the following child hood disease:

a) Chicken pox ☐ d) Diphtheria ☐

b) Measles ☐ e) Whooping Cough ☐

c) Mumps ☐ f) Polio ☐

- Did your child have any untoward/accident/fainting/epilepsy issues in past.

Please specify_____

- Emergency Permission:
  (Parents are to read carefully on following)

Sl. No.	Particulars	Yes	No
1.	I grant permission for the school appointed person to administer non-prescription medication such as Bonasin, Throat Cozenges, Glucose Powder etc.		
2.	I grant permission to obtain appropriate medical help for the student if there is an emergency and if after extensive efforts, parents cannot be contacted.		
3.	I hereby give permission for emergency measures to be initiated in case of accident or sudden illness with the understanding that will be notified immediately.		
4.	I understand that I, as a parent, am solely responsible for all hospital, doctor & medical bills and shall not hold the school responsible for any mishap.		
5.	I understand that I, as a parent is solely responsible and in my opinion, my child is fit to stay in Residential school.		

Father's Signature & Date

Mother's Signature & Date

Father's Thumb impression

Mother's Thumb impression