Parameters of Annual Medical Checkup

Date/Month/Year				
General Cleanliness				
Allergy (if any)				
Past/ Family history				
GENERAL EXAMINATION				
Height (in cm's)				
Weight (in kg)				
Nails				
Hair				
Skin				
Anemia				
(Mild/Moderate/Severe/Nil)				
E.N.T. EXAMINATION				
Ear (External/Internal)				
Rt. L.F.				
Nose				
Throat (tonsils)				
Neck (Lymph Nodes)				
DENTAL EXAMINATION				
Tooth Cavity				
Plaque				
Gum Inflammation				
Stains				
Tartar				
Bad Breath				
Gum Bleeding				
SYSTEMIC EXAMINATION				
Respiratory System				
Cardiovascular System				
Abdomen				
Nervous System				
EYE EXAMINATION				
Conjunctiva/Cornea:				
Vision				
Right Eye				
Left Eye				
Squint				

Preferred hospital where the child can be taken in case of emergency with the name and contact number of the Doctor:

……

Undertaking: All information is correct and nothing has been concealed. I/We authorize the school to take my/our daughter for emergency treatment to the hospital.

Signature: ……..…….. …….…… ……

Father Mother legal Guardian (If any)

ST. ANNE'S KINDERGARTEN

SECTOR 32-C, CHANDIGARH

SCHOOL HEALTH RECORD

PLEASE NOTE: PARENTS ARE REQUESTED TO DISCLOSE ALL INFORMATION AS THIS MAY BE VITAL IN CASE OF AN EMERGENCY AND IN THE HANDLING OF YOUR CHILD.

General Information

Name :……..	**Father's/Guardian's (if any) Name**
Class :……	**……**
Admission No.:……	**Mother's Name…….**
Date of Birth :……	**Address:……..……**
Recent Passport sized Photograph of the child(not more than one month old) 	**……** **PHONE NOS** **Office: ……** **Residence: ……** **Mobile ……..…….....**

EMERGENCY CONTACT NUMBER

NAME AND CONTACT NUMBER OF DOCTOR IN CASE OF EMERGENCY

Note: The Schools before implementing the Health Cards may consult a local Registered practitioner.

Both sides of this form to be submitted at the time of Orientation Day

Name of the student: ……..Class……..…

Date of birth: ……. ……. Blood group: ……..……

Father's name: ……. Mother's name: ……..

Address:……

Admission no. : …….

VACCINATIONS

Immunization	Age Recommended	Due Date	Date
BCG	0-1 Month		
Hepatitis B	At Birth		
	1 Month		
	6 Months		
DPT	2 Months		
	3 Months		
	4 Months		
HB	2Months		
	3 Months		
	4Months		
Oral Poilo	At Birth		
	1 Month		
	2 Months		
	3 Months		
	4 Months		
Measles	9 Months		
MMR	16 Months		
DPT+OPV+HB	18 Months		
Typhoid	2 Years		
Hepatitis B (2 Doses)	2 Years		
Chicken Pox	After age 1 year		
DT-OPA	4 1/2 Year		

Booster Doses

Typhoid (Every3 Year)			
TT (Every 5 Year)			
Other Vaccines			

Doctor's Observation……

……

Signature: …… …… ……

Father Mother Legal Guardian (if any)

Central Board of Secondary Education

HEALTH HISTORY

Allergies to	What Happened	How severe	Medication Taken at the Time of Allergies
Worm Infection	What Happened	Consulted with Doctor or Not	Medication Taken for W.I.
Any Other Medical Issue			

Has the child undergone any surgery? If yes, please mention the details below:

……

Does the child have any problem during physical activity: …….

Signature: …… …….. ……..

Father Mother Legal Guardian (if any)

To be certified by a Registered Medical Practitioner

Date of physical examination …… Height……. Weight…….

B.P. : …… Pulse : ……

CLINICAL EXAMINATION	NORMAL	RECOMMENDATION	
Head/Neck			
Abdomen			
Surgery			
Serious Illness			

Summary of Current Health Condition,_____-_____

_____

Any previous medical history/ or any other information pertaining to the child's physical/ mental/ emotional well being?

Does your daughter have any medical issue that the school needs to be aware of, to ensure the safety of your daughter?

e.g. seizures/fits, cardiac, diabetes, blood pressure etc. _____

Fits to participate in age specific physical/ other activity_____

Fit to participate in age specific physical/other activity with precaution_____

_____

Should not participate in the following sport/ activity: _____

Name of Doctor…… Signature of Doctor ……..

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