BIRLA PUBLIC SCHOOL PILANI(RAJ.)

STUDENT'S MEDICAL HISTORY PROFORMA,TO BE FILLED BY PARENTS

DATE.....

NAME OF STUDENT..... REGISTRATION No.....

FATHERS NAME..... CLASS.....

DATE OF BIRTH .....

I. BLOOD GROUP.....

II. PHYSICAL DEFORMITY (YES/NO)IF YES PLEASE SPECIFY.....

III. CHRONIC DISEASE eg. FITS, ASTHMA,ANEMIA,JOINT DISEASE,DERMATITIS,TONSILLITIS,ETC. (YES/NO)IF YES PLEASE SPECIFY

.....

.....

IV. TAKING ANY MEDICINES (YES/NO)IF YES PLEASE SPECIFY

.....

V. ALLERGY TO ANY DRUGS OR FOOD (YES/NO)IF YES PLEASE SPECIFY

.....

VI. USING SPECTS OR NOT (YES/NO) IF YES PLEASE SPECIFY

.....

VII. HISTORY OF ANY OPERATION (YES/NO) IF YES PLEASE SPECIFY

.....

VIII. UNDER GOING DENTAL TREATMENT (YES/NO) IF YES PLEASE SPECIFY

.....

IX. SUFFRING FROM COMMUNICABLE DISEASE eg.SKIN DISEASE,TUBERCULOSIS,ETC. (YES/NO) IF YES PLEASE SPECIFY

.....

X. IMMUNIZATION DETAILS:.....

.....

Consent:

I Mr./Mrs. .....Father/Mother/Legal Guardian of .....Consent of any form of surgery(and anesthesia) for my child that may be deemed necessary by school authorities after consultation with the concerned specialist ,in case of(a) an emergency (b)routine minor surgery. I also authorize the school authorities to sign on my behalf. I also authorize the school authorities and the doctors of the referral centre (in case of referral) to treat my ward with any medicines ,investigations ,invasive procedures, which they may feel necessary in the interest of my ward's health .I shall not hold the school staff responsible for any inadvertent mishap/complication during or as a result of the treatment during his stay in the school. This remains valid throughout the stay of my child in the school.

Signature of Parent or Legal Guardian. .....Date.....

Mobile no.....

Email id.....

Name of Signatory and Complete
Address.....
.....
.....

IF ANY DETAILS ARE NOT READILY AVAILABLE,MAY BE SENT BY MAIL TO ID:
kantilal020285@bpspilani.edu.in

VIDYA NIKETAN
BIRLA PUBLIC SCHOOL, PILANI
Medical Pro forma

Student's Name: _____

House No_____ Class _____ House:_____

PLEASE NOTE THE FOTTOWING CAREFULLY:

1. It is important in both the child and School's interest that a true and detailed picture is given of the child's health.
2. Full details regarding treatment and investigations must be sent to the Resident Medical Officer (RMO) in the case of a child with a history of:

    a) Bronchial Asthma
    b) Seizures
    c) Rheumatic Arthritis/Fever
    d) Any other chronic illness.

    In case of a child not responding satisfactorily to treatment, it may become necessary to request his withdrawal from the School.

3. Consultations with the specialist listed in Part-II are obligatory and should be completed within the last 15 days before the child's departure for School.

4. If the child wears spectacles, it is imperative that he has 2 pairs:-
    a) One for use,
    b) One to be deposited at the M I Room/Health Care Centre.

5. The child must be duly immunized specifying dates in accordance with the requirements in this pro forma. Any new immunizations done during the vacations must be mentioned in the column on Immunization in Part-II.

6. This pro forma must be completed in all respect and brought to the School in hard copy on 4th April, 2016, failing which your child will not be allowed entry into the School.

7. The School cannot accept children who are suffering from any infectious skin diseases (e.g. ringworm, scabies, etc.). If an infectious skin disease is contracted during the holidays, treatment is to be obtained and the RMO must be informed about the same.

8. If your child is receiving any medication, please ensure that the RMO is informed about the same and the entire course or supply of medicine along with the prescription is to be handed over immediately on arrival, to the RMO.

STATEMENT OF THE MEDICAL PRACTITIONER

The bearer of this form is a student of Vidya Niketan Birla Public School, Pilani.

Each candidate is to be medically examined, by concerned specialist, for physical fitness. Your assessment and certification in Part II, of the form is to indicate whether the student is medically fit to undertake all activities of the School and list any medical disability or conditions which are likely to interfere with or be aggravated by any activity of the School.

1. **General Practitioner:**
2.

(a) Height _____ Weight _____ Pulse _____ BP _____ RR _____

(b) Systemic examination:

PART I

(To be filled in by the respective specialist)

(i) General Appearance _____

(ii) Lymph Nodes: _____

(a) Cervical _____ (b) Post Cerv _____ (c) Axillary _____ (d) Inguinal _____

(iii) CVS _____ (iv) Respiratory System. _____

(v) Abdomen _____ (vi) C.N.S. _____

Investigations:

(a) Blood:

(i) Hb _____ (ii) TLC _____ (iii) DLC _____

(iv) ESR _____ (v) Blood Sugar _____ (vi) S. Bilirubin _____

(vii) HbsAg _____ (viii) HCB _____ (ix) HIV _____

(b) Urine

(R/E) _____

Remarks:

This is to certify that _____ is mentally and physically fit to join a residential School.

Date: _____ _____

(Signature & Official Stamp)

2. Dermatologist (Skin) Specialist:

To r/o any infection of the:

(a) Please rule out any contagious infection _____

Remarks : _____

Date: _____ _____

(Signature & Official Stamp)

3. ENT Specialist:

Please rule out any ENT problem, including hearing impairment

Remarks: _____

Date: _____ _____

(Signature & Official Stamp)

4. Dental Surgeon (Dentist):

(a) Oral Hygiene _____

(b) General Condition of Gums _____

(c) Caries _____

(d) No. of fillings done _____

(e) If orthodontic treatment/follow-up is required specify dates _____

Date: _____ _____

(Signature & Official Stamp)

5. Ophthalmologist (Eye Specialist):

(a) Please rule out any eye related problem

(b) Acuity of Vision: (i) With Spectacles RE_____ LE_____

(ii) Without Spectacles RE_____ LE_____

Remarks:_____

Date: _____

_____

(Signature & Official Stamp)

6. Surgical Specialist:

(i) To R/o:

(a) Hernia_____ (b) Haemorrhoid_____

(c) Hydrocele_____

(ii) P/E of:

(a)Appendix_____

(b)Genitalia_____

Remarks:_____

Date: _____

_____

(Signature & Official Stamp)

TO BE FILLED IN BY THE PARENT/GAURDIAN

Allergic to:_____

DURING THE VACATION DID YOUR CHILD:-

a) Generally keeps good health? YES/NO
b) Suffer from any serious illness? YES/NO

If YES then specify_____

c) Undergo any surgery? YES/NO

If YES then specify_____

d) Sustain any injury fracture? YES/NO

If YES then specify_____

e) Manifest with any allergy? If yes, elaborate YES/NO
If YES then specify_____

f) Suffer from Bronchial Asthma? If yes, elaborate YES/NO

7. Consent:

(a) I Mr/Mrs._____ Father/Mother/Legal Guardian of _____consent to any form of surgery (and anaesthesia) for my child that may be deemed necessary by the School authorities after consultation with the concerned specialist, in case of (i) an emergency (ii) routine minor surgery. I also authorize the School authorities to sign on my behalf.. I also authorize the School authorities and the doctors of the referral centre (in case of referral) to treat my ward with any medicines, investigations, invasive procedures, which they may feel necaeeasy in the interest of my ward's health. I shall not hold the School staff responsible for any inadvertent mishap/complication during or as a result of the treatment during his stay in the School. This remains valid throughout the stay of my child in the School

Signature of Parent or Legal Guardian_____ Date_____

Mobile No._____

Email id _____

Name of the Signatory and Complete Address_____

_____

_____

PART II

8. IMMUNIZATION: (fill up only new immunizations or boosters done during vacation)

(a) T.A. i.e. Typhoid/Para-Typhoid A (or A.KD. for under 12 yrs. valid for 3 yrs.)

Batch No._____ Date_____

(b) T.T. (i.e. Tetanus Toxoid valid for 4 yrs.)

Date_____

(c) Chicken pox vaccine & *booster dose:

Date:_____

(d) Hepatitis-B:

Date_____Dose 1

Date_____Dose 2

Date_____Dose 3

(e) Hepatitis A:

Date_____Dose 1

Date_____Dose 2

*Booster dose is advised for any child who has had his first dose more than 8 years ago. First dose is to be given to a child of any age who has not been vaccinated nor has suffered from the disease in the past.

Note: You may follow the advice of your family doctor/pediatrician with regards to the vaccination program.