ST. KAREN'S SECONDARY SCHOOL, PATNA

MEDICAL DECLARATION & HISTORY OF THE CHILD

Name of the student..... Class.....

Date..... Admission No. ..... Registration No. .....

Name of the Parent .....

Dear Parent,

You are requested to kindly answer the questions given below.

MEDICAL HISTORY OF THE WARD : (To be filled in by the Parent)

1. Has your child been fully immunised against : (Please tick)

Polio	Diphtheria	Pertussis	Tetanus	Hepatitis B.
Yes/No	Yes/No	Yes/No	Yes/No	Yes/No

2. Has your child had any of the following infections ? If so when ?

Scabies	Dandruff	Ringworms	Athletes foot.
Yes/No	Yes/No	Yes/No	Yes/No

Date : ....

3. In the recent past has your child suffered from any of the following respiratory diseases like :

Bronchitis	Pneumonia	Asthma	Is he/she prone to such conditions ?
Yes/No	Yes/No	Yes/No	Yes/No

4. Has your child ever suffered from tuberculosis ? Yes/No

   When was the last X-ray chest done. Date.....

5. Has you child ever had fits/epilepsy ? If so, when and what was the diagnosis ? Yes/No.

   Diagnosis .....

   .....

   .....

   (Kindly attach a Xerox copy of the past report)

6. Has your child ever suffered from incontinence of urine ? Yes/No

   Does he/she wet the bed ? Yes/No

7. Does your child suffer from frequent headaches ? Yes/No

8. Is your child allergic to pollen, dust, antibiotics or any food substance ? Yes/No

   Does he/she have frequent rashes, itching, swelling of lips etc. due to the allergy ? Yes/No

9. Has your child ever undergone any major operations ? If so, please state the operation and mention the date.

10. Blood group and type.....

I Mr/Mrs. ..... F/o./M/o. Miss/Master..... hereby declare that the informations furnished in this form by me is True to the best of my knowledge and if the same is found contrary then I shall agree to any action as taken by the School Management.

Signature of the Parent in full : ..... Date.....

MEDICAL EXAMINATION

(To be completed by the Parent)

Name of the student Master/Miss .....

Class..... Admission No. ..... Registration No. .....

Parent's Name .....

Address .....

..... Pin .....

Phone : (O)..... (R)..... Mobile .....

(To be completed by the Doctor)

DATE OF MEDICAL EXAMINATION :

1. Height .....
2. Weight .....
3. Condition of teeth .....
4. Condition of gums .....
5. Condition of skin .....
6. Condition of feet .....
7. Condition of spine .....

SYSTEMIC EXAMINATION

1. General Examination .....
2. Respiratory system .....
3. Cardiovascular system .....
4. Abdominal and genital urinary system .....
5. Central Nervous system .....

SPECIAL SENSES

1. Speech .....
2. Hearing .....
3. Vision .....
4. Remarks if any.....

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Signature and Stamp of the Doctor Date..... Registration No. .....