

# School Health Record

## General Information

<p>Name: .....</p> <p>Date of Birth: .....</p> <div data-bbox="332 918 633 1243" style="border: 1px solid black; width: 185px; height: 145px; margin: 10px auto;"></div>	<p>Admission No: .....</p> <p>Father's Guardian's Name &amp; Address:.....</p> <p>.....</p> <p>.....</p> <p><b>Phone No. Office:</b> .....</p> <p><b>Residence :</b> ..... <b>Mobile:</b> .....</p>
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*Note: The schools before implementing the Health Cards may consult a local Registered Medical Practitioner.*

Name of the School Logo etc.

**BOTH SIDES OF THIS FORM TO BE SUBMITTED AT THE TIME OF ADMISSION**

Name of the Student ..... M/F ..... Class.....

Date of Birth ..... Blood Group .....

Father's Name ..... Mother's Name .....

**VACCINATIONS**

Immunization	Age Recommended	Due Date	Date
BCG	0-1 Month		
Hepatitis B	At Birth		
	1 Month		
	6 Month		
DPT	2 Months		
	3 Months		
	4 Months		
HB	2 Months		
	3 Months		
	4 Months		
Oral Polio	At Births		
	1 Months		
	2 Months		
	3 Months		
	4 Months		
Measles	9 Months		
MMR	16 Months		
DPT+OPV+HIB	18 Months		
Typhoid	2 Years		
Hepatitis A (2 Doses)	2 Years		
Chicken Pox	After age 1 year		
DT - OPA	4½ Year		

**BOOSTER DOSES**

Typhoid (every 3 years)			
TT (every 5 years)			
Other Vaccines			
Signature of Father .....		Signature of Mother .....	

# HEALTH HISTORY

ALLERGY TO ANY FOOD, ADHESIVE TAPE, BEE STING

Allergy	What Happened	How Severe	Medication Taken at the Time of Allergy

• Does the child have any problem during physical activity .....

Signature of Father ..... Signature of Mother.....

## To be certified by a Registered Medical Practitioner

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

B.P..... Pulse ..... Vision L ..... R.....

Squint..... Conjunctiva..... Cornea..... Ear L..... R.....

Clinical Examination	Normal	Recommendation	
Head/Neck			
Abdomen			
Surgery			
Serious Illness			
Nails			
Skin			

Summary of Current Health Condition, \_\_\_\_\_

\_\_\_\_\_

- Fit to Participate in age specific physical activity \_\_\_\_\_
- Fit to participate in age specific physical activity with precaution \_\_\_\_\_
- Should not participate in competitive sport \_\_\_\_\_

Signature of Doctor .....

Name of the Doctor.....

