MEDICAL FORM

MALPANI FOUNDATION'S

॥ तेजस्विनावधीतमस्तु ॥

DHRUV GLOBAL SCHOOL

CBSE School

Sr.No.-26/2/1,Katraj Bypass Road, Undri, Pune-411060
Cell : +91 9146058080
Admissions: admissions.undri@dhruv.edu.in
Accounts: accounts.undri@dhruv.edu.in
Transport: transport.undri@dhruv.edu.in
Visit us at : www.dhruv.edu.in

●PERSONAL INFORMATION

1) Name of the student : _____ Grade_____

2) Date of birth : | | | | | | | | | Blood Group | |

DD MM YY

3) Gender : MALE | | FEMALE | | Height in cm | | Weight in kg | |

4) Emergency Phone Nos. :_____ Contact person :_____

Affix recent passport size color photograph

(Parents can consult their family doctor to fill following information)

●VACCINATIONS

Immunization	Age Recommended	Given Date
BCG	0-1 Month	
Hepatitis B	At Birth	
	1Month	
	6 Month	
DPT	2 Months	
	3 Months	
	4 Months	
HIB	2 Months	
	3 Months	
	4 Months	

Immunization	Age Recommended	Given Date
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 age1year	
DT - OPV	4½ Year	

● BOOSTER DOSES

Typhoid (every 3 years)			
TT (every 5 years)			
Other Vaccines			

● HEALTH HISTORY: Please keep the Class Teacher and the school doctor informed in case your ward has any specific medical issues

ALLERGY TO ANY FOOD, ADHESIVE TAPE, BEE STING, MEDICINE, etc.

Allergy	Details	Severity level	Medication Prescribed

Does your child suffer from: Asthma : Yes / No

- Congenital Heart Disease : Yes / No
- Fits / Convulsions /Epilepsy : Yes / No
- Dizziness/ fainting spells : Yes / No
- Vertigo : Yes / No
- Frequent Headache / Neuritis : Yes / No

Past History: Any Operation, Typhoid, Malaria, Dengue, Injuries, etc. Write in short_____

_____

Family History: Asthma, Hypertension, Diabetes, Epilepsy, etc. Write in short_____

_____

*Does the child have any problem during physical activity_____

*Is he/she a bed wetter? If so, how frequently does this happen? _____

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

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FOLLOWING INFORMATION IS TO BE FILLED IN BY A REGISTERED MEDICAL PRACTITIONER AND SUBMITTED AT THE TIME OF ADMISSION

Name of the student -			
Date of physical examination -			
Systemic Examination	Nervous		
	Respiratory		
	Abdomen		
	Cardio Vascular		
Muscle, Skeletal System Knee/Flat Feet/Lordosis/Kyphosis			
Anemia: (Mild, Moderate, Severe or Absent)			
General Appearance			
Pulse-		**Blood Pressure-**	
Weight Kg. Actual Percentile -		**Height Cms Actual Percentile -**	
Eye		**Rt. Eye**	**Lt. Eye**
	Vision		
	Squint		
	Conjunctiva		
	Cornea		
Dental & Oral Cavity	Gums, Soft Tissue, Colour, Stains, Plaque, Teeth Occlusion caries, Tooth Cavity, Tarter, Tonsils Lymph Nodes		
Ear		**Rt. Ear**	**Lt. Ear**
	External Ear		
	Middle Ear		
Skin			

Head/ Neck:- _____ Nails:- _____ Nose:- _____

Important findings: _____

Remarks: _____

_____ _____

Signature of Parent **Signature with stamp of Registered medical practitioner**