The Ummed International School, Abu Road

Medical History Form

(For New Admissions Only)

Part - A

Name of the Student _____

Scholar No._____House _____

Class_____Date of Birth (dd/mm/yyyy) _____

Identification Mark _____

Blood Group_____Height in cm._____Weight in kg._____

Affix recent passport size coloured photograph with a light background

Medical History of the child

Whether the child has a history of

1. Epilepsy	Yes ☐	No ☐
2. Bronchial Asthma	Yes ☐	No ☐
3. Breathing problems	Yes ☐	No ☐
4. Fits or Convulsion	Yes ☐	No ☐
5. Tuberculosis	Yes ☐	No ☐
6. Heart Disease	Yes ☐	No ☐
7. Syncope / Fainting	Yes ☐	No ☐
8. Migraine / Headache	Yes ☐	No ☐
9. Nocturnal Enuresis (Bed Wetting)	Yes ☐	No ☐
10. Somnambulism (Sleep Walking)	Yes ☐	No ☐
11. Epistaxis (Nose Bleeding)	Yes ☐	No ☐
12. Congenital Anomalies	Yes ☐	No ☐
13. Diabetes	Yes ☐	No ☐

Immunization Record

Has the child been immunized for the following? (Indicate Yes/No)

1. Typhoid	Yes ☐	No ☐
2. Meningitis	Yes ☐	No ☐
3. Hepatitis A	Yes ☐	No ☐
4. Hepatitis B	Yes ☐	No ☐
5. Chicken Pox	Yes ☐	No ☐
6. Swine Flu	Yes ☐	No ☐
7. Poliomyelitis (Polio vaccine)	Yes ☐	No ☐
8. Diphtheria / Pertussis / Tetanus (Triple Antigen)	Yes ☐	No ☐
9. Measles / Mumps / Rubella (M.M.R.)	Yes ☐	No ☐
10. Tuberculosis (BCG)	Yes ☐	No ☐

Kindly attach a photocopy of the immunization card duly signed by the Physician.

1. Is your child sensitive to any drug or suffers from G6PD syndrome – Yes ☐ No ☐

   If yes, please give details _____

2. Is your child allergic to any food item - Yes ☐ No ☐

   If yes, please give details _____

3. Any other known allergies_____

4. Is your child taking any medication, if yes please give details _____

5. Please provide details if your child has undergone any surgery / sustained any injury or facture in the recent past _____

6. Please give details, if your child has suffered from any infectious disease or other illness in the recent past _____

7. Kindly provide any other details related to your child's health that is worth mentioning

   _____

   _____

_____

Signature of the Father / Mother

Name of Father / Mother_____

Date _____

Place _____

_____

Signature of the Physician with official seal

Name of the Physician _____

Registration No. _____

Address _____

_____

Date _____

Important Note for Parents

1. In case your child uses spectacles it is important that he brings three pairs of spectacles to school along with the latest prescription. Two pairs of spectacles and the latest prescription should be deposited with the Resident Dame / House Master.
2. Dental
   (i). If orthodontic treatment is going on then provide the Name, Address and Contact no. of the Orthodontist. Also provide further plan of treatment and follow ups.
   (ii). The school authorities shall not be responsible for any follow up or treatment failure in orthodontic treatment.
3. Under no circumstances medicines are to be given or kept with the child without informing the school Doctor. If the child is presently under treatment, then a complete medical report along with prescription and medicines are to be submitted in the School Infirmary.

4. A through Dental, Eye, Skin and ENT check-up / treatment must be completed during the vacation and the detailed report should be submitted at the school infirmary at the beginning of each term.
5. The school does not take the responsibility for getting the child vaccinated. Kindly get the necessary vaccinations done from time to time.

Part - B

SYSTEMIC EXAMINATION

Respiratory system _____

Cardiovascular system _____

Abdomen _____

Nervous system _____

Digestive _____

Excretory _____

Bones & Joints _____

Any other specific systemic illness

If any, please give details _____

_____

_____

_____

Signature of the Examining Doctor with Official Seal

Name of the Examining Doctor _____

Registration No._____

Address _____

_____

Date _____

Medical Certificate

This is to certify that I have thoroughly examined (Name of the Student) _____

Son/Daughter of _____, studying in The Ummed International School in Class

_____and have found him/her medically fit and in good health for normal Residential

School life.

I also certify that he/she does not suffer from any ailment, sickness, mental or physical problem or transmittable / contagious disease.

_____

Signature of the Examining Doctor with Official Seal

Name of the Examining Doctor _____

Registration No._____

Address _____

_____

Date _____