MALWA SCHOOL

GIDDARBAHA-152101

Allergy	Blood Group

HEALTH INFORMATION

It is essential that we have a complete and accurate medical record of each new entry . Will you please complete every item of this questionnaire and return it after having had it countersigned by a Register Medical Practitioner ? Chest X-Ray must be submitted at the time of admission.

Student's Name in Full ______________________________

Date of Birth ______________________________

Please indicate if the child has suffered from any of the following infectious disease, and give approximate dates

1. Chicken pox ....
2. Measles ....
3. German Measles ....
4. Diphtheria ....
5. Mumps ....
6. Small pox ....
7. Whooping Cough ....
8. Typhoid ....
9. Polio ....
10. Any other disease ....

Has he suffered from:-

1.Rheumatic Condition ....
2. Dysentery ....
3. Fits or Convulsions ....
4. Worms ....
5. Bed Wetting ....
6. Heart Conditions ....
7. Mental Conditions ....
8. Night Bindness ....
9. Details of any major or minor operation ....

Indicate the condition of :-

1.Ears ....

4. Nose ....

2. Teeth .... 6. Throat ....

3. Eyes .... 7. Chest ....

Has the boy, or parent, suffered from :-

1. Diabetes ....

2. Leucoderma ....

3. Asthma ....

4. Any other hereditary complaints ....

1.Immunisation : Give dates :- 2. Re-Vaccinated against Small pox .... 3.Inoculated against Tripple Antigen .... 4. Inoculated against Typhoid .... 5. Inoculated against Cholera .... 6. Inoculated against Polio .... 7. Inoculated against Tuberculosis ....

Please delete the inappropriate words :- 1. I do/do not want him to give polio (oral) vaccine 2. I do/do not want him to give BCG vaccine 3. He is/is not allergic to penicillin

Name and Signature of Parent/Guardian ....

Date ....

Countersigned ....

Appointment ....

School Doctor's Remarks :-

Date ....

Submit Print