



DELHI PUBLIC SCHOOL - PANIPAT CITY

Medical Form

(For Office Use Only)

Student's Name: _____
(USE BLOCK LETTERS ONLY)

(As per previous school records)

Sex: Male Female Age Class to which admitted

Blood Group: **Height:** **Weight:**

Name of Parent _____

Address for Correspondence _____

_____ **PIN** _____

Telephone Office _____ Fax _____

(With ISD Residence _____ Fax _____

& STD Code) Mobile _____ **E-mail** _____

Name of Local Guardian _____ Relationship _____

Address for Correspondence _____

_____ **PIN** _____

Telephone Office _____ Fax _____

(With ISD Residence _____ Fax _____

& STD Code) Mobile _____ **E-mail** _____

Infectious Diseases <i>(Please underline the child has had)</i>	Measles - German Measles - Scarlet Fever - Chicken Pox - Mumps -your disease(s) Whooping Cough - Epidemic viral Hepatitis - Malaria- Typhoid Fever - Poliomyelitis - Tetanus - Diphtheria - Meningitis - Endocarditis Mononucleosis (Glandular fever) - Toxoplasmosis, TB, Pulmonary Diseases / Primary Complex etc. Recent exposure to any other contagious / infectious disease (give details).	
Other Illness <i>(Please underline)</i>	Respiratory Digestive Heart & Circulation Blood	Frequent tonsillitis Otitis (Ear infection), Bronchitis Asthma Sinusitis Epistaxis Gastric - Digestive - Intestinal complaints Congenital or acquired heart diseases - Peripheral Circulatory troubles (Chillblain or others) Anemia - Prolonged bleeding - Capillary fragility or other

	Joints & Bones	Rheumatic illness - Trauma requiring special attention
	Endocrine	Diabetes - Thyroid and Parathyroid problems or other
	Metabolism	Obesity - Failure to thrive - Other problems
	Skin (Epidermic)	Eczema - Urticaria - other contagious or non-contagious skin diseases - Fungal infection
	Allergies	Drug - Foods - Odours - Chemical Products - Plants Dust (Pollen) - Hair - Feathers or Others
	Urinary	Kidney trouble - Bladder : Cystitis - Enuresis / Kidney Stones
	Genital (Concerns mostly girls)	Eg. Incapacitating periods or other troubles
	Teeth	Condition of Teeth - necessary care or supervision / Braces
	Glasses or Contact lenses	If spectacles are worn, please supply three sets.

Date of the most recent illness: _____

Particular wishes of the parent: _____

Please state whether the child is fit and able to participate in sports and expeditions. If not, please give

1. Medical Certificate _____

2. Concise Physical Report _____

Supplementary remarks & information _____

(send analysis, x-rays, Medical Reports. etc.)

Clinical Evaluation - Health Certificate _____

Signature of Medical Practitioner _____
Physician with seal & Regn. No. _____

Place _____ Date _____

Supplementary Information _____

