



# The International School Bangalore

## Medical Report for students

NOTE : PLEASE USE BLOCK LETTERS TO COMPLETE THIS FORM

All questions MUST be answered honestly, please submit to Resident Officer at the time of admission

SURNAME																		
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FIRST NAME																		
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DATE OF BIRTH										SEX	MALE		FEMALE	
	DD		MM			YY								

Next of kin information : .....

Name : .....

Address : .....

ISD code / country code / area code / local number

Emergency Phone No .:

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E-mail : ..... Fax : .....

### Medical History Form ( Part I )

SL. NO.	QUESTION	Date	RESPONSE Remarks
1	Has your ward had any of the following Childhood diseases ?		
	(a) Chicken Pox		
	(b) Measles		
	(c) Mumps		
	(d) Diphtheria		
	(e) Whooping Cough		
	(f) Polio		
2	Has he / she suffered from any of the following other diseases ?		
	(a) Tuberculosis		
	(b) Enteric (Typhoid) Fever		
	(c) Dysentery		
	(d) Malaria		
	(e) Dengue Fever		
	(f) Rheumatic Fever		
	(g) Infective Hepatitis (Jaundice)		
	(h) Mononucleosis		
	(i) other disease / illness if any		
3	Does / did he / she suffer from any ENT		

	problems ?		
	(a) Frequent colds		
	(b) Frequent nosebleeds		
	(c) Frequent sore throat (Tonsillitis)		
	(d) Any symptoms of deafness		
	(e) Tooth or Gum problems		
	(f) hay Fever / allergies		
4	Does / did he /she suffer from any Chest or respiratory problems ?		
	(a) Rheumatic Heart disease		
	(b) Other Heart problems		
	(c) High Blood Pressure		
	(d) Haemophilia (excessive bleeding)		
5	Does / did he /she suffer from any GI / GU conditions ?		
	(a) Appendicitis		
	(b) Abdominal pain		
	(c) Bladder / Urinary infection		
	(d) Diarrhoea / dysentery		
	(e) gall Bladder		
	(f) Frequent indigestion		
	(g) Haemorrhoids		
	(h) Hernia		
	(i) Kidney infection		
6	Does / did he /she suffer from any Skin conditions ?		
	(a) Eczema		
	(b) Impetigo		
	(c) Frequent boils		
	(d) scabies		
7	Does / did he /she suffer from any Neurological conditions ?		
	(a) Convulsions / Epilepsy / Fits		
	(b) Dizziness / Fainting spells		
	(c) Vertigo		
	(d) Frequent headaches		
	(e) Neuritis		
8	Does / did he /she suffer from any Other medical conditions ?		
	(a) Insomnia		
	(b) Sleep Walking		
	(c) Depression		
	(d) Hysteria		
	(e) Mental illness		
	(f) Psychiatric treatment		
9	Has he / she had any surgical operation, head or other serious injury, or fracture of the bones ? If so, please give particulars.		
10	Is he / she a bed-wetter ? If so, how		

	frequently does this happen ?		
11	Has he / she been X-rayed at any time ? If so, when and for what ?		
12	Are his / her eyes and eyesight normal ?		
13	Does he / she wear glasses or contact lenses (if yes, attach prescription) or suffer from any other eye ailment ?		
14	Are his / her teeth generally in good order ?		
15	Does he / she need orthodontic treatment ?		

### Medical History Form (Part II)

Height : Cms	Weight : Kgs	Temp :	Pulse :	B.P. :
Chest (full expiration) :		Chest (full inspiration) :		
Blood Group & RH :		Blood & WBC : Hgb-grams%		
Montoux Test (if done) : Positive / Negative				
Pathology (Blood, urine & stool, if applicable) :				
Skin conditions :				
Eyes / Vision (attach prescription if glasses or contact lenses are worn)				
Ears / Hearing				
State of appendages / extremities				
State of Spine & Neck, Posture :				
Signs of flat feet or other defects				
Breasts				
Glands				
Throat / Tonsils				
Piles / Fissure				
Abdomen / Hernia / Spleen				
Pelvo-Rectal				
Cardio Vascular System				
Respiratory System				
Neurological / Central Nervous System				

IMMUNISATION RECORD	PRIMARY (DD, MM & YY)	BOOSTER (DD, MM & YY)
BCG		
POLIO		
DPT		
MEASLES		
MMR		
TETANUS TOXOID		
TABC		
TYPHOID		
HEPATITIS 'A'		
HEPATITIS 'B'		
OTHERS		

This is to certify that I have conducted a through medical examination of ..... and find that he / she is in a fit state of physical and mental health to join a residential school and does not suffer from any infectious disease. He / she (tick one) .....is / ..... not permitted to participate in games and physical education activities.

Remarks / Restrictions : .....  
.....  
.....  
.....

Date .....  
Regd No .....  
Name of Medical Practitioner .....  
Address .....  
.....  
.....

Signature & Stamp of Medical Practitioner

Contact No . (Off : .....

Contact No. (Res) : .....