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																		

FIRST NAME																		

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 .:

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 / allerbies		
4	Does / did he /she suffer from any Chest or respiratory problems ?		
	(a) Rheumatic Heart desease		
	(b) Other Heart problems		
	(c) High Blood Presure		
	(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) Fequent 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-wette ? 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 appendagess / 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 : .....
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Date ..... Signature & Stamp of Medical Practitioner
Regd No .....
Name of Medical Practitioner .....
Address .....
.....
.....

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