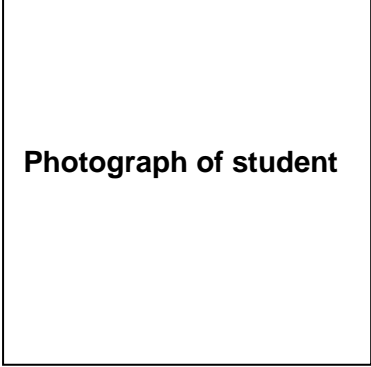


SAINIK SCHOOL HEALTH RECORD**General Information**

Name:	Admission No:
Date of Birth	
 Photograph of student	Father's/ Mother,s /Guardian's Name & Address:
	Phone No. Office
	Residence : Mobile:

Note : - The schools before implementing the Health Cards may consult a local Registered Medical Practitioner

BOTH SIDES OF THIS FORM TO BE SUBMITTED AT THE TIME OF ADMISSION

Name of the Student M/FClass.....

Date of Birth Blood Group

Father's Name Mother's Name

VACCINATIONS

Immunization	Age Recommended	Due Date	Date
BCG 0-1	Month		
Hepatitis B	At Birth		
	1 Month		
	6 Month		
DPT	2 Months		
	3 Months		
	4 Months		
HB	2 Months		
	3 Months		
	4 Months		
Oral Polio	At Births		
	1 Months		
	2 Months		
	3 Months		
	4 Months		
Measles	9 Months		
MMR	16 Months		
DPT+OPV+HIB	18 Months		
Typhoid	2 Years		
Hepatitis A (2 Doses)	2 Years		
Chicken Pox	After age 1 year		
DT – OPA	4½ Year		

BOOSTER DOSES

Typhoid (every 3 years)		
TT (every 5 years)		
Other Vaccines		
Signature of Father	Signature of Mother	

HEALTH HISTORY**ALLERGY TO ANY FOOD, ADHESIVE TAPE, BEE STING**

Allergy	What Happened	How Severe	Medication Taken at the Time of Allergy

Does the child have any problem during physical activity:

Signature of Father :Signature of Mother

TO BE CERTIFIED BY A REGISTERED MEDICAL PRACTITIONER

Date of physical examination..... Height Weight.....

B.P..... PulseVision LR.....

Squint..... Conjunctiva..... Cornea.....Ear L R.....

Clinical Examination	Normal	Recommendation	
Head/Neck			
Abdomen			
Surgery			
Serious Illness			
Nails			
Skin			

Summary of Current Health Condition, -----

Fit to Participate in age specific physical activity _____

Fit to participate in age specific physical activity with precaution _____

Should not participate in competitive sport _____

General Appearance						
Weight Kg Actual Percentile						
Eye Vision R .E L.E						
Squint Conjunctiva Cornea						
Rt Lt						
Ears :						
External Ear :						
Middle Ear :						
ORAL CAVITY						
GUMS						
Colour						
Teeth Occlusion						
Caries						
TONSILS						
Lymph. Nodes						
Pulse						
B.P						
Nails						
Skin						
Muscle, Skeletal System Knee/ Flat Feet/Lordosis/kyphosis						
Systemic Examination						

Signature of Doctor

Name of the Doctor
& Seal