Delhi Public School, Dwarka

PHASE I, DWARKA SECTOR-3, DWARKA, NEW DELHI, DELHI 110078

MEDICAL FORM

1. STUDENT NAME: ……..…… …… ……..
   First Name **Middle Name** **Last Name**
2. DATE OF BIRTH: ……/……/……..... In Words: ……..
   ...……...……
3. GENDER: ……. BLOOD GROUP: …….
4. Father's NAME: ……..……
5. Mother's NAME: ……..……

VACCINATIONS

Immunization	Due Date	Date of vaccination		
BCG				
Hepatitis B				
DTP				
HIB				
OPV				
Measles				
MMR				
DPT + OPV + HIB				
Typhoid				
Hepatitis A(2 doses)				
Chicken Pox				
Previous History of Surgery (if any) :				

BOOSTER DOSES

Immunization	Due Date	Date of vaccination		
Typhoid (every 3 years)				
TT (every 5 years)				
Other Vaccines				
Signature of Father …….. Signature of Mother ……				

Name of the Doctor …… **Signature of Doctor ……**
(official stamp with registration number)

HEALTH HISTORY

(Part- II)

1. Date of Physical examination..... Height ..... Weight.....

   Weight at time of birth..... Length at time of birth .....

   Any special medical treatment given in first 4 weeks after birth

   .....

   .....

2. **Allergy for example : (to any food, adhesive tape, bee sting etc.)**

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

3. **Summary of Current Health Condition (if any),**

   .....

   .....

   .....

4. **Fit to participate in physical activity** **Yes/ No/ with precaution (please tick)**

Name of the Doctor ..... **Signature of Doctor .....**
(official stamp with registration number)

DECLARATION BY PARENT **(Part - III)**

I _____ Father/ Mother / Local Guardian of _____ student of Class/ Sec. _____Admission No. _____hereby confirm that the above said information about my ward is correct.

Date: _____ **Signature of Parent / Guardian _____**

MEDICAL FITNESS CERTIFICATE

(Part- IV)

(to be signed by the Medical Officer , D.P. S. Dwarka)

I have verified the above information regarding Master/ Miss _____Class / Section _____and he/ she is medically fit/ unfit for admission in the School.

Remarks , if any_____

_____

Date : _____ **Signature of Medical Officer_____**
D.P.S. Dwarka