**Indian School Muladha**

**MEDICAL RECORD**

1. Name of the student (as in the Passport): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. G.R. No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Class:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Blood Group: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_cm Weight: \_\_\_\_\_\_\_\_\_\_\_\_kg
5. Vision: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Left) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Right)

1. Teeth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Oral Hygiene: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent's/Guardian's Details:**

|  |  |  |
| --- | --- | --- |
|  | **Father/Guardian** | **Mother** |
| Name:  |  |  |
| Mobile No.:  |  |  |
| WhatsApp No.:  |  |  |

|  |  |  |
| --- | --- | --- |
| **Vital Information:**  | **Yes** | **No** |
| Allergies (Food/Medicines, etc.) |  |  |
| Bronchial Asthma |  |  |
| Congenital Heart Disease |  |  |
| Diabetes Mellitus |  |  |
| Epilepsy |  |  |
| G6PD (Glucose 6 Phosphate Dehydrogenate Deficiency) |  |  |
| Rheumatic fever  |  |  |
| Thalessemia |  |  |
| Others (Specify, if any) |  |  |

**PRESCHOOL VACCINATIONS**

|  |  |  |
| --- | --- | --- |
| **Immunization** | **Recommended Age** | **Given Date** |
| BCG | 0 - 1 month |  |
| Hepatitis B | At birth |  |
| 1 month |  |
| 6 months |  |
| DPT | 2 months |  |
| 3 months |  |
| 4 months |  |
| HB | 2 months |  |
| 3 months |  |
| 4 months |  |
| OPV | At birth |  |
| 1 month |  |
| 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 one year |  |
| DT + OPV | 4th year |  |
| Any other Vaccines |  |  |

1. Is there any special area of medical concern related to your child? Please describe below so that special care may be taken.

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1. Is your child on any medication? Please give details.

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1. If the above is yes, please give the prescribing/attending doctor’s name and contact number.

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1. Has he/she undergone any surgical operations/met with any accident?

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**Important Note:**

If your ward has any medical problem, and precautions to be taken while at school, please inform in writing the nature of problem, emergency medication to the class teacher with your contact number. Please DO NOT send medication to the school with your child. If it is very essential then it may please be handed over to the infirmary staff or else this may inadvertently be consumed by other children.

Please update the above record regularly for your child’s benefit.

Signature of the parent\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_