RiverDale International Residential School / Junior College

FOR BOYS & GIRLS

# MEDICAL REPORT FOR STUDENTS

NOTE : PLEASE FILL THIS FORM IN BLOCK LETTERS ONLY

All questions MUST be answered correctly and honestly.

Name of Child

(Leave a space between first name, middle name and last name)

Date of Birth

D D M M Y Y Y Y

Male or Female _____

Father's Name

(Leave a space between first name, middle name and last name)

## Next of kin information

Name _____

Address _____

Emergency Phone No.

| ISD Code | Local Number | Area Code | Country Code |
|---|---|---|---|
| | | | |

Email _____ Fax _____

## MEDICAL HISTORY FORM (Part 1)

| SR. NO. | QUESTION | DATE | RESPONSE / REMARK |
|---|---|---|---|
| 1 | Has your child had any of the following Childhood diseases ? Please underline. | | |
| | Chicken Pox, Measles, Mumps, Diptheria, Whooping Cough, Polio | | |
| 2 | Has he / she suffered from any of the following other diseases ? | | |
| | Tuberculosis, Enteric ( Typhoid ) Fever, Dysentery, Malaria, Dengue Fever, Infective Hepatitis ( Jaundice ), Rheumatic Fever,Mononucleosis, other disease / illness if any | | |

| | | | |
|---|---|---|---|
| 3 | Does / did he / she suffer from any ENT problems ? | | |
| | Frequent nosebleeds, Frequent colds, Frequent sore throat ( tonsillitis ), Symptoms of deafness, Tooth or Gum problems, Hay Fever, Any type of allergies | | |
| 4 | Does / did he / she suffer from any Chest or Respiratory problems ? | | |
| | High Blood Pressure, Rheumatic Heart disease, Other Heart problems, Haemophilia ( excessive bleeding ) | | |
| 5 | Does / did he / she suffer from any GI / GU conditions ? | | |
| | Abdominal pain, Appendicitis, Bladder / Urinary infection, Diarrhoea / Dysentery, Gall bladder, Frequent indigestion, Haemorroids, Kidney infection, Hernia | | |
| 6 | Does / did he / she suffer from any skin conditions ? | | |
| | Scabies, Frequent boils, Eczema, Impetigo | | |
| 7 | Does / did he / she suffer from any Neurological conditions ? | | |
| | Dizziness / Fainting spells, Vertigo' Convulsions / Epilepsy / Fits, Neuritis, Frequent headaches | | |
| 8 | Does / did he / she suffer from any other medical conditions ? | | |
| | Mental illness, Depression, Hysteria, Psychiatric treatment, Insomnia, Sleep walking | | |
| 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, what is the frequency of occurrence ? | | |
| 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 any orthodontic treatment ? | | |

NOTES

## MEDICAL HISTORY FORM (Part II)

| | |
|---|---|
| Height Cms. Weight Kgs. | Temp. Pulse B.P. |
| Chest (full expiration) | Chest (full inspiration) |
| Blood group and RH | Blood & WBC Hgb-grams % |
| Montoux Test (if done) - | Positive / Negative |
| Pathology (blood, urine & stool, if applicable) | |
| Skin condition | |
| Eyes / Vision (attach prescription for glasses or lenses) | |
| 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 | |
| Cardin 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 thorough medical examination of _____ and 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 ☐ is not permitted to participate in games and physical education activities.

Remarks / Restrictions

The above stated information is true and correct.

Signature of parent / guardian _____

Date _____ Signature & stamp of Medical Practitioner

Regd No. _____

Name of Medical Practitioner _____

Address _____

_____

_____

_____

Contact No. (Off.) _____ Contact No. (Resi.) _____