Declaration of Medical Fitness

(To be submitted at the time of enrollment)

Candidate's Statement / Declaration

Name of Student:_____

In BLOCK LETTERS

1. Disease diagnosed in past : Yes / No
   If yes, please specify :

2. Past surgical Record : Yes / No
   If yes, please specify :

3. Allergies (if any) : Yes / No
   If yes, please specify :

4. List of prescribed medicines : Yes / No
   If yes, please specify :

5. Identification mark :

I hereby declare that all the above answers are true and correct to the best of my knowledge. I fully understand that above information is collected for the benefit of the students during the stay in the Avantika University campus and is to be given accurately.

Signature of the Parent / Guardian: Candidate's Signature:

Date :

Place :

MEDICAL CERTIFICATE

I, the undersigned, Dr. ……,

have examined all necessary reports of Mr./Ms. …….....

Son of Dr./Mr/Mrs …… and certify

that details given below are true to the best of my knowledge.

1. Height …….cm
2. Weight …….kg
3. Psychological disturbance: Yes / No

   (If yes, please specify):
4. Vaccination status

Hepatitis B	Yes / No
Hepatitis A	Yes / No
Meningitis	Yes / No
Chicken pox	Yes / No
Measles, Mumps, Rubella	Yes / No
Any other vaccination taken	Yes / No
(If yes, please specify):	

5. ECG Report :
6. Chest X-Ray :
7. Diabetes :
8. Blood Sugar (F/PP):
9. HBS Ag :
10. Creatinine :
11. HIV - I & II :
12. Urine Reports :

Date:

Place:

Signature and Stamp

Name of Doctor:

Name of Hospital**:**

(Above information is to be completed by a doctor with qualification not less than MD Medicine/*Physician, and should be supported with all latest examination reports.)*

EXAMINATION OF EYES

I, the undersigned, Dr. ……, have examined the all necessary reports of Mr./Ms. …… Son of Dr./Mr/Mrs …….. and certify that details given below are true to the best of my knowledge.

Near Vision	Right Eye-	Left Eye-
Far Vision	Right Eye-	Left Eye-
Acuity of Vision	Right Eye-	Left Eye-
Color Vision	Right Eye-	Left Eye-

Signature and Stamp of the Ophthalmologist
Name of Doctor:
Name of Hospital**:**
Date:
Place: