HEALTH RECORD

The Health Record is a confidential document for the use of Health Center only.

After completion of the entire form by a Doctor/Physician, please return it to Health Center.

Name of Student _____ Year of Admission _____

Gender ☐ Male ☐ Female Date of Birth _____

Email ID _____ Contact No. _____

Emergency Contacts (Please provide two names to contact in case of emergency.)

Name	_____	_____
Relationship	_____	_____
Contact No.	_____	_____
Email ID	_____	_____

Medical and Surgical History (If yes, please specify.)

Yes	No		Comments
☐	☐	Operation	_____
☐	☐	Seizure	_____
☐	☐	Cardiovascular	_____
☐	☐	Respiratory	_____
☐	☐	Any other	_____

If the student is under care for any condition, please attach clinical reports to assist the continuity of care.

Current Health Issues (Please check the current health issues. If yes, specify the issue and current medications.)

Yes	No		Current Issues and Medications
☐	☐	Allergy	_____
☐	☐	Asthma	_____
☐	☐	Diabetes	_____
☐	☐	Seizure	_____
☐	☐	Any other	_____

If the student is under care for a chronic condition/serious illness, please attach clinical reports to assist the continuity of care.

Physical Examination

Date of Examination _____

Height _____ Blood Group _____

Weight _____ Blood Pressure _____

BMI _____

Please ☑ for normal and ☒ for abnormal. If ☒, specify the abnormalities.

☐ Skin	_____	☐ Abdomen	_____
☐ ENT	_____	☐ Genitalia	_____
☐ Dental	_____	☐ Neurologic	_____
☐ Lungs	_____	☐ Psychological	_____
☐ Heart	_____	☐ Other	_____

Screening

Vision	Pass	Fail	Hearing	Pass	Fail	Postural Screening	Pass	Fail
Right Eye	☐	☐	Right Ear	☐	☐	Scoliosis	☐	☐
Left Eye	☐	☐	Left Ear	☐	☐	Kyphosis	☐	☐
Stereopsis	☐	☐				Lordosis	☐	☐

COVID – 19 Immunization

Yes	No	Dose	Name of Vaccine Received	Date of Vaccination
☐	☐	Dose 1	_____	_____
☐	☐	Dose 2	_____	_____

Please attach the vaccination certifications to this form. As per the Government Rules, all the students are required to receive COVID-19 vaccinations. Students will NOT be permitted entry to campus housing unless Health Center receives the proof of vaccination.

☐ Yes ☐ No The student may participate fully in the academic program, including physical education and competitive sports.

If No, please provide remarks below.

Signature of Doctor/Physician (with Seal)

_____ Name _____

_____ Contact No. _____