



# the **Srijan** school

## HEALTH CERTIFICATE - 2024-25

1. Name of the Child : \_\_\_\_\_
2. Class : \_\_\_\_\_
3. Date of Birth : \_\_\_\_\_
4. Father's Name : \_\_\_\_\_
5. Mother's Name : \_\_\_\_\_
6. Blood Group : \_\_\_\_\_ R.H. Factor \_\_\_\_\_
7. Immunization History :
  - a) BCG : Yes / No
  - b) DPT : Yes / No
  - c) Oral Polio : Yes / No
  - d) Measles/ MMR : Yes / No
  - e) Typhoid : Yes / No
  - f) Meningitis : Yes / No
  - g) Any Other : Yes / No
8. History of past illness:
  - a) Specific diseases suffered in the past.....
  - b) Operation undergone in the past, if any specify.....
  - c) Allergies, if any.....
  - d) Any other disease for which the child is on regular medication.....
  - e) Any Congenital Anomaly.....
  - f) Special needs, if any.....

Date \_\_\_\_\_

Name of the Parent \_\_\_\_\_ Signature of Parent \_\_\_\_\_

Emergency Phone No. \_\_\_\_\_

### Medical Certificate of Fitness (From Registered Doctor)

This is to certify that I, Dr. \_\_\_\_\_ have examined  
\_\_\_\_\_ aged \_\_\_\_\_ years, D/o / S/o  
\_\_\_\_\_ on dated \_\_\_\_\_.

His/ Her visual acuity is normal/ corrected with glasses. There is no other illness, which would render the child unfit to attend school. He/ She is fit to attend school.

### Signature of Doctor

Name: \_\_\_\_\_

Regn. No. : \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

Tel. No. \_\_\_\_\_