Annexure - A

SCHOOL HEALTH RECORD

GENERAL INFORMATION

Name :	Admission No : .....
	Father's/Guardian's Name & Address : .....
Date of Birth :	.....
	.....
Photo	.....
	Phone No. Office : .....
	Residence : .....
	Mobile : .....

Note : The schools before implementing the Health Cards may consult a local Registered Medical Practioner.

NAIPUNNYA PUBLIC SCHOOL

Edakkunnu, Paduapuram P O, Angamaly - 683576

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BOTH SIDES OF THIS FORM TO BE SUBMITTED AT THE TIME OF ADMISSION

Name of the student .....M/F..... Class .....

Date of Birth : .....Blood Group : .....

Father's Name ..... Mother's name.....

VACCINATIONS

Immunization	Age Recommended	Due date	Date
BCG	0-1 Month		
Hepatitis	At Birth		
	1 Month		
	6 Months		
DPT	2 Months		
	3 Months		
	4 Months		
HB	2 Months		
	3 Months		
	4 Months		
Oral Polio	At Birth		
	1 Months		
	2 Months		
	3 Months		
	4 Months		
Measles	9 Months		
MMR	16 Months		
DPT+OPV+HIB	18 Months		
Typhoid	2 Years		
Hepatitis A (2Doses)	2 Years		
Chicken Pox	After age 1 year		
DT-OPA	4 ½ Years		

BOOSTER DOSES

Typhoid (every 3years)			
TT(Every 5 years)			
Other Vaccines			

Signature of Father..... Signature of Mother ....

.....												
General Appearance												
Weight (Kg) Actual Percentile												
Height (Cms)												
Eye Visoion R E												
L E												
Squint Conjunctiva Cornea												
Rt. Lt Ears: External Ear Middle Ear												
ORAL CAVITY GUMS Colour Teeth Occlusion Caries TONSILS Lymph Nodes												
Pulse												
BP												
Nails												
Skin												
Muscle, Skeletal system Knee/Flat /Feet/ Lordosis/Kyphosis												
Systemic Examination												

HEALTH HISTORY

ALLERGY TO ANY FOOD, ADHESIVE TAPE, BEE STING

Allergy	What happened	How Severe	Medication Taken at the Time of Allergy

- Does the child have any problem during physical activity

Signature of Father..... Signature of Mother.....

To be certified by a Registered Medical Practitioner

Date of physical examination..... Height..... Weight.....

BP..... Pulse..... Vision L..... R.....

Squint..... Conjuctiva..... Cornea..... Ear L.....R.....

Clinical Examination	Normal	Recommendation	
Head/Neck			
Abdomen			
Surgery			
Serious Illness			
Nails			
Skin			

Summary of Current Health Condition _____

_____

_____

Fit to Participate in age specific physical activity _____

Fit to participate in age specific physical acitivity with precaution _____

_____

Should not participate in competitive sport _____

Signature of Doctor .....

Name of the Doctor .....