HILLWOODS ACADEMY

Preet Vihar, Delhi

SCHOOL HEALTH RECORD

General Information

Name ______________________	Admission No. ______________
Date of Birth ______________________	Father's / Guardian's Name & Address ________
Student's Photograph	______________________ ______________________ ______________________ ______________________
	Phone No. Office ______________________
	Residence ______________________
	Mobile ______________________

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 B	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 Month		
	2 Months		
	3 Months		
	4 Months		
Measles	9 Months		
MMR	16 Months		
DPT+OPV+HIB	18Months		
Typhoid	2 Years		
Hepatitis A (2 Doses)	2 Years		
Chicken Pox	After age 1 year		
DT – OPA	4½ Year		
-------------------------------BOOSTER DOSES-------------------------------			
Typhoid (every 3 years)			
TT (every 5 years)			
Other Vaccines			

Signature of Father ______________________ Signature of Mother ______________________

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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 ________

B.P. ________ Pulse ________ Vision L ________ R ________

Squint ________ Conjunctiva ________ Cornea ________ Ear L ______ R ______

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

Summary of Current Health Condition, ______________________________

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- Fit to Participate in age specific physical activity ____________________
- Fit to Participate in age specific physical activity with precaution ____________________

  ____
- Should not participate in competitive sport ____________________

Name of the Doctor ____________ Signature of the Doctor ____________

General Appearance					
Weight (Kg) Actual Percentile					
Height (cms) Actual Percentile					
Eye Vision	R. E.				
	L. E.				
Squint Conjunctiva Cornea					
Ears (Rt. Lt.)	External Ear				
	Internal Ear				
ORAL CAVITY GUMS Colour Teeth Occulusion Caries TONSILS Lymph Nodes					
Pulse					
B. P.					
Nails					
Skin					
Muscle, Skeletal System Knee/ Flat Feet/ Lordosis/ Kyphosis					
Systemic Examination					