MEDICAL FITNESS CERTIFICATE

(To be Completed by a Parent's Only)

Name of the Student :

Date of Birth: _____ Class in which the child seeks to be admitted _____

School where the student last attended: _____

Parent's Name & Occupation : _____

(To be Completed by a Medical Practitioner in Govt. Service)

Age : _____ Height : _____ Weight : _____

Chest inspiration: _____ Chest expiration : _____

Abdomen : _____ Oral Hygiene & Teeth : _____

C.V.S. : _____ Ear, Nose, Throat : _____

C.N.S. : _____ Immunization Status : _____

RE : _____ Covid : _____

Vision : _____ BCG : _____

LE : _____ Polio _____

Blood Group : _____ DPT : _____

If any deformity, its nature & extent : _____

If any operation, particulars : _____

Marks of Identity 1. _____

2. _____

(Date, nature, results, condition of scars)

Other Remarks & Recommendations : _____

_____

Signature, name and designation
of Examining Physician

Name and Signature of
the Parent

Note to the parents: *Parents should specially mention in the above column whether Hearing or Vision is impaired and any other problem which the student is prone to suffer or special attention to be given.*