



## HEALTH CERTIFICATE

(To be submitted at the time of admission)

(To be completed by Parent/Legal Guardian in CAPITAL letters in consultation with Medical Practitioner/Physician)

This certificate is to be attached to Students' Registration Form. Kindly do not leave any column blank.

NAME OF STUDENT \_\_\_\_\_ CLASS \_\_\_\_\_ SEC \_\_\_\_\_ YEAR \_\_\_\_\_

(To be filled in by the Parent) IMMUNIZATION RECORD	Please tick (✓) If given	Date and Year of giving
<u>Vaccines</u> <ol style="list-style-type: none"> <li>1. BCG</li> <li>2. DPT + Polio (Diphtheria, Whooping Cough &amp; Tetanus)</li> <li>3. DPT Booster + Polio Booster Dose-1 Dose-2</li> <li>4. H. Influenza B (HIB)</li> <li>5. Hepatitis B</li> <li>6. MMR – measles, mumps, rubella</li> <li>7. Chicken Pox</li> <li>8. Typhoid</li> <li>9. Hepatitis A</li> </ol>		
At the time of filling this form Eye Sight (R+) _____ (L+) _____ Height _____ Weight _____ Blood Group _____		Date of Check
<ul style="list-style-type: none"> <li>• Is the child suffering from any allergies – YES/NO If yes name _____</li> <li>• Is the child suffering from any physical problems – YES/NO (History of epilepsy, diabetes, asthma, food, flat foot and/or any other) If yes name _____</li> <li>• Is the child suffering from any psychiatric problem If yes name _____</li> <li>• Is the child having a learning disability – YES/NO If yes name _____</li> <li>• Is the child on any medication? If yes please mention _____</li> <li>• Please give the name of the child's pediatrician _____ Phone _____</li> <li>• In case of emergencies please give the Tel. no. of Contact Person and Doctors Tel. No. (in order of preference) 1<sup>st</sup> Contact _____ Phone _____ 2<sup>nd</sup> Contact _____ Phone _____ 3<sup>rd</sup> Contact _____ Phone _____</li> <li>• In case of any allergic problem what help do you expect* _____</li> </ul> <p><b>Note:</b> *Schools are equipped only to provide first aid. It shall be the responsibility of the parent to take measures they deem fit in case of any serious problem.</p> Name of the Parent/Guardian _____ Date _____ Signature of Parent/Guardian _____		

**Navrachana Vidyapani Vidyalaya**

**Vaododara-8.**

Dt. – 1<sup>st</sup> November'09

Circular No. VV/22/2009-10

Dear parents,

It has been observed that every year when parents need to get the Health Certificate, it becomes inconvenient for them and we as a School sometimes don't get Correct and Complete information. Now onwards it shall be done at the time of new admissions, but for the existing students we require parents to fill in all information, accurately, with dates when such shots were given to their ward for our permanent data on health of each child. Kindly please check your record and then only fill in. it shall be the responsibility of Parent to inform us on subsequent repetition/booster dozes what ever the case may be.

Name of Child \_\_\_\_\_ Age \_\_\_\_\_ Date & Year \_\_\_\_\_

Class and Section \_\_\_\_\_ Blood Group \_\_\_\_\_

With warm regards,

Rekha Mishra

Principal