Annexure:

MEDICAL AUTHORIZATION

(Must be completed in Full)

To be filled by Admission Office:

Student Name Admission No. House:

In case of a medical or surgical emergency, a written consent from parents or legal guardian is required. In the rare instance of the proper person being un-reachable, in order to avoid any delay that might jeopardize the life or recovery of a student, we request the parents' or legal guardians' for the following permission, with the understanding that every effort will be made to contact you in case of any emergency.

I Mr./Mrs. _____ hereby, authorize the RMO of or other appropriate Medical Staff member of _____ to carry out the necessary procedures for diagnosis, immunization, medical treatment and minor surgical treatment for my son /ward Mr. _____.

I hereby further authorize the RMO of _____ or any other physician/surgeons referred by the RMO, to give necessary anesthesia and perform emergency medical or surgical procedures for any occurrences of any adversities/repercussions, during the School term. In any such eventuality, despite due proper diligence and care having been exercised by the School Authorities, I further undertake to absolve the RMO, Principal and the School's Management of any entailing consequences.

Date _____ _____

Parent's/Legal Guardian's Signature

Name: (IN Block Letters):-_____

Relationship:-_____

MEDICAL HISTORY FORM

To be filled by Admission Office

Student Name Admission No. House:

This information is condiential and strictly for the use of it will assist us in proving your ward with optimal medical care while she is a student at not be revealed to any one without your knowledge and consent, other than for medical reasons.

PART I: GENERAL INFORMATION

(To be filled by the parent)

1. Father's/Legal Guardian's Name: _____

Mobile: _____ Email ID: _____

2. Mother's Name: _____

Mobile: _____Email ID: _____

PART II: MEDICAL EXAMINATION BY FAMILY PHYSICIAN

(Must be performed prior to entry into School)

(To be filled by the family examination physician)

TO THE EXAMINING PHYSICIAN: This student has been provisionally accepted to become a hostel inmate @ Sanskaar International School, Sulem Sarai, Allahabad.

Please review the student's medical history and complete this form. In a boarding School environment, it is very important that we have thorough medical information of all students.

This information is strictly for the use of INFIRMARY and will only be used for the medical care of the student.

Please note that a recent PPD urinalysis and HCT are required before enrollment

Name of Student: _____ Date of Birth: _____

Weight: _____ Height: _____ Blood Pressure: _____

Date of the blood analysis: _____

Hemoglobin: _____ TLC: _____

DLC: _____ ABO: _____

Date of urinalysis: _____

Glucose: _____ Protein: _____

Blood: _____ Other: _____

Date of Chest X-Ray: _____

Finding if any:

EYE EXAMINATION FORM

(To be filled in by examining Opthalmologist's)

To be filled by Admission Office:

Student Name: Admission No: House:

To Be filled up by the Doctor:

It is recommended that your ward have an eye examination before enrolling. The following information is requested in the event of eye trauma, broken glasses, lost contact lenses etc. The information will be on hand in the student's records to facilitate quick replacement at one of the local optometrist's offices. Students who wear contact lenses should also bring a current pair of glasses with them for any of the numerous situations that could preclude wearing contacts.

Prescription:

Distance Vision	Right	Left
Near Vision	Right	Left
Colour Vision	Right	Left

Contact Lens Information

Type (Brand):

Bic Series	Right	Left
Power Dia	Right	Left
Periph	Right	Left
Curves	Right	Left
Colour	Right	Left

Name of Ophthalmologist's or Optometrist's _____

MCI Registration Number: _____

Address:

_____

_____

Telephone (Landline with area Code):

_____

Mobile Number: _____

Date: _____

Signature with stamp.

Note: Kindly attach latest prescription by an examining Ophthalmologist.

Date of Immunization: Please Fill in all dates. The boosters are required before a student can enroll in School.

Name of Vaccines	First Dose	Second Dose	Third Dose	Booster Dose
Hepatitis B				
Hepatitis A				
HPV				
OPV				
MMR				
Chicken Pox				
BCG				
Tuberculosis				
IPV				
Typhoid				
Varicells Vaccines				

PleaseNote: If the ward did not or could not received any of vaccinations, the parents may request the RMO for the same in writing. The School will administer the requested vaccination in the nearest local hospital under the Supervision of School Staff medical staff, on Chargeable basis.

Family History:

PARTICULARS	FATHER	MOTHER
Living? (Yes/No)		
If No, cause of death		
Age		
State of Health (Good/Moderate/Poor)		
Occupation		

Please List siblings, their age and their health status:

Name	Age (Yrs.)	Health Status (Good/Moderate/Poor)

MEDICAL CERTIFICATE

(By the family physician of the student of his hometown)

To be filled by Admission Office

Student Name: Admission No.:
House:

To be filled up by the Doctor

In reference to my medical examination, I hereby certify that I have thoroughly examined your ward Mr. ……, son/ward of Mr. / Ms. …… and found him in good health and fit for normal school life and work.

I have particularly conducted his skin examination and certify that he is not suffering from any communicable/ non-communicable skin disease.

To the best of my knowledge and belief, he has not during the last thirty days, suffered from or been exposed to any infectious or contagious disease.

Further remarks, If any:
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Signature of Doctor (with seal):
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Name in block letters:
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Qualifications: …… Indian Medical Council No.:
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Address:
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Phone No.: ……

Date: ……

Important note for the Parents:
If this certificate is not produced on the date of joining School your ward may, at the discretion of the Principal, be kept in quarantine or sent back home.

Has any of immediate family member of student ever had any of the following?

Relationship & Comments

Tuberculosis Yes/No
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Diabetes Yes/No
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Kidney disease Yes/No
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Heart Disease Yes/No
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Rheumatoid arthritis Yes/No
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Gastrointestinal disease Yes/No
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Hepatitis Yes/No
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Asthma Yes/No
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Epilepsy Convulsion Yes/No

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Hypertension Yes/No

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Cancer Yes/No

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Bleeding Disorders Yes/No

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Elevated Cholesterols Yes/No

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REPORT OF MEDICAL HISTORY OF THE STUDENT

IMPORTANT: We urge you to be completely thorough in providing …… with the information requested. It is for the student's own safety and health that medical staff must be aware of such Problems.

1) Does the student have any chronic medical problem? Yes/No

If yes, please comment

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2) Does the student have a psychiatric problem, history of substance abuse, eating disorder, learning disability? **Yes/No**

If yes, please comment

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3) Does the student have any orthopedic problems due to **Yes/No**

Which limited athletic or physical activities are recommended?

If yes, please comment

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4) Does the student have any E.N.T. Problems? **Yes/No**

If yes, please comment

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5) Does the student have any respiratory problems? Yes/No

If yes, please comment

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6) Does the student have any cardiac problems? Yes/No

If yes, please comment

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7) Does the student have any gastro-intestinal problems? Yes/No

If yes, please comment

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8) Does the student have any genitor-urinary problems? Yes/No

If yes, please comment

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9) Did the student ever have any communicable disease? Yes/No

If yes, please comment

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10) Does the student have any skin related problems? Yes/No

If yes, please comment

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11) Does the student have any dental problems?

Yes/No

If yes, please comment

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12) Does she have any allergies to medications?

If allergic, please state to which medications and the nature of reaction:

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13) Does she have any severe allergies to food or insect venom (wheezing, breathing problem, generalized hives, shock and upper airway problem)? Please specify specific agents and the type of reaction:

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……

14) Would you like her to continue allergy injection at the hospital? Yes/No

15) Does your student have?

Asthma	Yes/No	Diabetes	Yes/No
Hyperactivity	Yes/No	Dermatitis	Yes/No
Epilepsy	Yes/No		

Please list medications taken chronologically and their prescribed dosage:

Medications	**Dosage**
1. ……	
……	
2. ……	
……	
3. ……	
……	
4. ……	
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5. ……

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6. ……

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7. ……

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8. ……

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9. ……

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16) Do you have any specific recommendation regarding the Medical care of this student? Yes/No

If yes, please comment

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17) Do you have any other health or health related concerns about Yes/No

Your ward while she is away from home?

If yes, please comment

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18) Do you have any medical insurance policy for your ward? Yes/No

If yes, please comment

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I hereby certify that I have thoroughly examined your ward Mr.. ……

Son/ward of Mr. / Ms. …… And found him in good health and fit for normal School life and word.

Name of examining physician: ……

……

MCI Registration Number: ……

……

Address:

……

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Telephone (Landline with area code): ……

Mobile Number: ……

……

Date: ……