La Martiniere Schools, Kolkata

MEDICAL CERTIFICATE

(TO BE FILLED BY A QUALIFIED MEDICAL PRACTITIONER)

1. Name_____ 2. Class _____

3. Date of Birth _____ 4. Weight _____

5. Height _____ 6. When was last inoculated for TABC? _____

BCG? _____

7. When was last inoculated for Triple ANTIGEN? _____

TETANUS? _____

8. When was last VACCINATED? _____

9. Is vision normal? _____

10. Is free from infectious diseases? _____

11. Is the condition of heart normal? _____

12. What is the general condition of health? _____

13. Has the child any major illness e.g. epilepsy? _____

14. Has any physical deformity? _____

15. What illness/es has the child in the last one year? _____

16. Is the child under treatment for asthma or respiration disorders? _____

17. Is the child under any medication for heart condition / epilepsy / asthma? _____

18. Any other remarks _____

19. Blood Group _____

_____	_____
Signature of Parent / Guardian	Signature of Medical Practitioner
	with Registration No. _____
Name _____	Name of Medical Practitioner _____
Address _____	Address _____
_____	_____
_____	_____
Phone No. _____	Phone No. _____
Mobile _____	Mobile _____
E-Mail _____	E-Mail _____
Date _____	Date _____