

PROVISIONAL MEDICAL CERTIFICATE

G.D. GOENKA PUBLIC SCHOOL, JAMMU

This is to certify that i have conducted a thorough medical examination of and find He/she is in a fit state of physical & mental health to join a school and does not suffer from any infectious/contagious disease.

He/she (tick one) is is not permitted to participate in games and physical education activities.

Remarks/ Restrictions

Date Regn. No. Signature & Stamp of Medical Practitioner

Name of Medical Practitioner

Address City

Emergency Contact No. Off# Resi# Mob#

STUDENT'S NAME GRADE

FOR OFFICE USE ONLY

Registration No. Date of receipt of Application

Admission No. Medical ID

Remarks

Medical History Form

www.gdgoenkajammu.org



D. GOENKATM
SCHOOL

G. D. Goenka Public School, Jammu

Governed by Om Prakash Bansal Charitable Trust (Regd.)



MEDICAL HISTORY FORM

G. D. GOENKA PUBLIC SCHOOL, JAMMU

Name Age Sex: Female Male
 Height cms Weight kgs Blood Group

STUDENTS'S HEALTH HISTORY

Has your child suffered from any of the following diseases in the past? if yes, please provide details.

	No/Yes: (Year)	Details
Chicken Pox		
Measles		
Mumps		
Tuberculosis		
Hepatitis A		
Hepatitis B		
Typhoid		
Convulsions		
Meningitis		
Asthma		
Recurrent Tonsillitis/Sinustis		
Headaches		
Kidney Problems		
Heart Problems		
Skin Problems/Allergy		
Hearing Problems / Hearing Aids		
Orthopedic Problems/Joint pains		
Congenital Problems		
Glasses / Contact lenses		
Dental / Gum Problem		
Diabetes		
Others		

ALLERGIES

DRUGS - Yes/ No. If "yes" please state which drug and treatment that has been or being given
 FOOD- Yes/ No. If "yes" please state which food and treatment that has been or being given
 ASTHMA - Yes/ No. If "yes" please state which drug and treatment that has been or being given
 OTHER - Yes/ No. If "yes" please state which article/substance and treatment that has been or being given
*Please attach Physician's prescription and advice.

IMMUNISATION RECORD (USE ONLY BLOCK LETTERS)

G.D. GOENKA PUBLIC SCHOOL, JAMMU

	Primary (DD,MM,YY)	Booster (DD,MM,YY)
BCG		
POLIO		
DPT		
MEASLES		
CHICKEN POX		
TYPHOID		
HEPATITIS 'A'		
HEPATITIS 'B'		
MENINGITIS		
H/O DOG BITE		
OTHERS		

INJURY / OPERATIONS(S)

Injury: Nature Date
 Operation(s) Nature Date

KNOWN MEDICAL ILLNESS/ CONDITIONS

Does your child suffer form any medical illness/ conditions for which he/she takes medication to control symptoms?

Does the child have ongoing Dental treatment now? If "yes" give details.

Had the student ever used services of a Psychologist, therapist or Psychiatrist? Yes/No. If "yes", give details.

*Please attach Physician's prescription and advice.