



Silver Oaks School

Medical History Record

(To be filled by a competent Medical Officer, (MBBS or Above) & to be submitted on the day of Interaction)

1. a. Name of the student: _____
b. Date of Birth: _____
2. a. Father's Name: _____
b. Mother's Name: _____
3. a. Is he/she free of speech defects like stammering etc.? _____
b. Is the hearing normal? _____
c. Visual Status (both eyes) _____
d. Are there any signs of congenital heart disease? _____
e. Is there any limb or locomotor Impairment? _____
f. Is he/she suffering from skin disease? _____
g. Has he/she undergone any surgery (Mention details of surgery, if any) _____
h. Mention disease/s from which he/she has suffered or is suffering from among the following:
Rheumatic fever, Typhoid, Tonsillitis, Fits, Enlarged glands in the neck, Brain Fever, Bronchial Asthma, Epilepsy, Tuberculosis, Jaundice. (Any other please mention) _____
i. Does he/she suffer from chronic diarrhea, Nocturnal Enuresis? _____
j. Has there been any case of tuberculosis in the family? _____
k. Is he/she allergic to the following? (Answer Yes or No and attach Allergy Test Report, if Yes)
Food _____ Clothing _____ Medicine _____ Dust _____ Any other _____
l. What is his/her blood group _____ RH Factor _____

Father's/Guardian's Signature

(Doctor's Sign. and Stamp)