



# HIM ACADEMY PUBLIC SCHOOL

Hira Nagar, Hamirpur (H.P.)-177001 Ph.: 01972-222829, 223428

Website: www.haps.co.in

e-mail: hapsn@himacademy.com

School Code: 1573 Affiliated to H.P. Board of School Education, Dharamshala Affiliation No.-14056

1. Name of the student: 

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2. Father's Name: 

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3. Address: 

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Photograph of student attested by the Medical Officer

4. Height (cm): \_\_\_\_\_

5. Visual Standard (both eyes): \_\_\_\_\_

6. Hearing: \_\_\_\_\_

7. Dental: \_\_\_\_\_

8. Speech Defects (stammering etc.) : \_\_\_\_\_

9. Any skin disease: \_\_\_\_\_

10. Physical deformities: \_\_\_\_\_

11. Sign of congenital heart disease: \_\_\_\_\_

12. Any history of chronic diarrhoea: \_\_\_\_\_

13. Is the child allergic to anything? If yes, give details: \_\_\_\_\_

\_\_\_\_\_

Allergy to any serum or drug: \_\_\_\_\_

14. Blood Group: \_\_\_\_\_

15. Medicines prescribed at the time of admission (if any): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

16. Any other information for the school doctor: \_\_\_\_\_

\_\_\_\_\_

**17. Has he had :**

- a) Chicken Pox ?
- b) Diphtheria ?
- c) Measles ?
- d) Mumps ?
- e) Rheumatic Fever ?

**Yes/No**

\_\_\_\_\_ If so, when ? \_\_\_\_\_  
 \_\_\_\_\_ If so, when ? \_\_\_\_\_  
 \_\_\_\_\_ If so, when ? \_\_\_\_\_  
 \_\_\_\_\_ If so, when ? \_\_\_\_\_  
 \_\_\_\_\_ If so, when ? \_\_\_\_\_

**18. Has he been successfully :**

- a) Inoculated against Typhoid ?
- b) Actively immunized against :  
 I) Diphtheria ?  
 ii) Whooping Cough ?  
 iii) Any other disease ?

**Yes/No**

\_\_\_\_\_ If so, when ? \_\_\_\_\_  
 \_\_\_\_\_ If so, when ? \_\_\_\_\_  
 \_\_\_\_\_ If so, when ? \_\_\_\_\_

**19. Has he had :**

- a) Fits ?
- b) Any discharge from ear/ears drum ruptured ?
- c) Asthma ?
- d) Incontinence of Urine ?

**Yes/No**

\_\_\_\_\_ If so, when ? \_\_\_\_\_  
 \_\_\_\_\_ If so, when ? \_\_\_\_\_  
 \_\_\_\_\_ If so, when ? \_\_\_\_\_  
 \_\_\_\_\_ If so, when ? \_\_\_\_\_

**20. Has he/she been bitten by any Animal (Dog, Monkey etc.)**

\_\_\_\_\_ If so, when ? \_\_\_\_\_

**21. Has he/she had any serious illness ?**

If so, give particulars and dates.

\_\_\_\_\_  
\_\_\_\_\_

**22. Did he undergo any surgical operation ?**

If so, give particulars and dates.

\_\_\_\_\_  
\_\_\_\_\_

**23. History of serious hereditary ailments in the family.**

\_\_\_\_\_

**Signature of Parent/Guardian**

Name : \_\_\_\_\_

Relation : \_\_\_\_\_

**Signature of student**

**Signature of Medical Officer**

Name : \_\_\_\_\_

Address : \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Stamp

Place: \_\_\_\_\_

Date: \_\_\_\_\_