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 ____