DAKSHANA FOUNDATION

MEDICAL REPORT FORM

Name: _____ Blood Group : _____

Dakshana Roll No.: _____ Color Blindness: Yes/No

Address: _____

Physical History: (Please tick the appropriate answer if the student has suffered from any of these in the past)

Malaria: Yes/No T.B.: Yes/No Typhoid: Yes / No

Asthma: Yes/No Chicken Pox: Yes/No

Physical Examination:

Age : _____ Weight (Kg) : _____

Height (cm) : _____ Heart : _____

Lungs : _____ Nutrition : _____

Urine Examination:

Albumin : _____

Nutrition : _____

Blood Pressure : _____

Eye Sight : _____

Identification Mark: _____

Date: Signature:

Name: Dr.

Address:

Reg. No.:

Note: 1. Medical Certificate should be undersigned by authorized doctor (M.D.)