



**MEDICAL FITNESS CERTIFICATE (2020-21)**

Name of the child \_\_\_\_\_ Form No. \_\_\_\_\_

Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_

Session \_\_\_\_\_ Class \_\_\_\_\_

Father's Name \_\_\_\_\_

Telephone No (Residence) \_\_\_\_\_ (Office) \_\_\_\_\_

Residential Address \_\_\_\_\_

\_\_\_\_\_ Delhi \_\_\_\_\_

Office Address \_\_\_\_\_

**GENERAL EXAMINATION-**

1. Blood Group\* \_\_\_\_\_ 2. Hb gm % \* \_\_\_\_\_

3. Height in cms \_\_\_\_\_ 4. Weight in kg \_\_\_\_\_

5. Pulse rate \_\_\_\_\_ 6. Respiratory rate \_\_\_\_\_

7. Is the child allergic to any medicine - \_\_\_\_\_

8. Has the child been hospitalized ever, if so specify the ailment & period of hospitalization-

9. Is the child on any regular medication- \_\_\_\_\_

10. Speech (Clear / not clear)- \_\_\_\_\_

**Doctor's Note and Fitness Verification** \_\_\_\_\_

Doctor's Name- \_\_\_\_\_

Signature & Date- \_\_\_\_\_

Stamp- \_\_\_\_\_

**\*Blood Test Reports are required to be submitted along with the Medical Fitness Certificate.**

## VACCINATION RECORD

(To be certified by a Registered Medical Practitioner)

Immunization	Age Recommended	Due Date	Date
BCG	0-1 Month		
Hepatitis B	At Birth		
	1 Month		
	6 Months		
DPT	2 Months		
	3 Months		
	4 Months		
HIB	2 Months		
	3 Months		
	4 Months		
Oral Polio	At Birth		
	1 Month		
	2 Months		
	3 Months		
	4 Months		
Measles	9 Months		
MMR	16 Months		
DPT+OPV+HIB	18 Months		
Typhoid	2 Years		
Hepatitis A (2 Doses)	2 Years		
Chicken Pox	After 1 Year		
DT-OPV	4.5 Years		

Father's Signature: \_\_\_\_\_

Name and Signature of Doctor: \_\_\_\_\_

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

\_\_\_\_\_

Mother's Signature: \_\_\_\_\_

Stamp of Doctor: \_\_\_\_\_

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

\_\_\_\_\_