SR No. _____

HAYDE HERITAGE ACADEMY
KOTDWARA

MEDICAL FORM

Student's Name _____
First Name Middle Name Last Name

Grade _____ Sec _____ Gender M ☐ F ☐ Date _____ / _____ / _____
dd mm yyyy

Blood Group ____ Height: _____ cms Weight: _____ kgs Identification Mark _____

EMERGENCY CONTACT

Person to Call _____ Relationship _____ Tel: _____

ALLERGIES

Is your child allergic to anything? Y / N _____

What is the treatment _____

Does the child suffer from Epilepsy / Asthma / Suffers from any other conditions_____

FOR YOUR INFORMATION

Any medication to be administered at School requires a prescription from the medical practitioner treating your child.

MEDICAL PERMISSION

I give my consent to the School Nurse to administer over the counter medication for common ailments**.**

EMERGENCY PERMISSION

I give my consent for emergency measures to be taken in case of an emergency situation arising due to an accident / violent injury / medical or surgical emergency with the understanding that I (the father/ the mother / the guardian of the student) shall be notified / informed as soon as possible. The school will accept no responsibility for any unforeseen incident that may occur due to the administration of medicine / treatment in both emergency and non-emergency situations, though necessary precautions are taken.

I declare that the above information I have provided on this form is complete and correct and that I will notify the Medical Center in writing if any changes are required to be made.

Parent's Signature _____

Date: _____

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HISTORY OF IMMUNIZATION

All the children must have completed their childhood minimum vaccination requirements for their age as per the **National Immunization Schedule** at the time of seeking admission to Pathways World School. Please indicate the date of Immunization of the child against each.

1.	**Poliomyelitis (Polio Vaccine)**	_____	**Yes**	_____	**No**
2.	**Diptheria / Pertussis /Tetanus (triple Antigen)**	_____	**Yes**	_____	**No**
3.	**Measles / Mumps / Rubella (MMR)**	_____	**Yes**	_____	**No**
4.	**Tuberculosis (BCG)**	_____	**Yes**	_____	**No**
5.	**Hepatitis B**	_____	**Yes**	_____	**No**
6.	**Hepatitis A**	_____	**Yes**	_____	**No**
7.	**Influenza**	_____	**Yes**	_____	**No**

I, Dr _____ have examined the child and declare him medically fit to join the school.

Name of the Physician _____ Signature of the Physician _____

Registration No. _____ Address _____

Physician's Stamp_____