

**Notes**

- We will rely on the information provided by you in this form. If required, your signature on the form also gives the physician, selected by Youreka Outbound Services Pvt. Ltd., permission to hospitalize or provide medical treatment to your child. Please use an extra sheet if you need to explain in detail.
- If your child is currently using any medication, please mention this and ensure that it is carried to the program. These will be deposited with the doctor and issued as per requirement.
- If your child uses prescription glasses, please ensure that an extra pair is carried to the program.

Name of the Student \_\_\_\_\_ Date of birth \_\_\_\_\_ Gender M/F \_\_\_\_\_

Class \_\_\_\_\_ Division \_\_\_\_\_ Program Code \_\_\_\_\_ Campus \_\_\_\_\_ **Blood Group :**

**Doctor's details [to be contacted in case of emergencies]**

(1) Doctor's name \_\_\_\_\_ Contact number \_\_\_\_\_

(2) Doctor's name \_\_\_\_\_ Contact number \_\_\_\_\_

**Any special needs?** (Please state clearly if there is anything you wish the campus doctor should know regarding your child's health and medical needs.)

**1. Allergies**

Type [ Medicines, food, contact, respiratory ]	Response- i.e. skin rash, itching, breathing difficulty, pain in abdomen, swelling over eyes or body.
	Description:
<b>What remedial action do you adopt in case of the allergy?</b>	

**2. Existing ailments or special conditions [ Please attach reports ].**

Ailment	Medication	Dosage	Remarks/instructions for school/college

**3. Family history [ Diabetes, Cardiac Ailments, Hypertension, Arthritis, fits, etc ]**

Diabetes Yes <input type="checkbox"/> No <input type="checkbox"/>	Cardiac problems Yes <input type="checkbox"/> No <input type="checkbox"/>	High Blood Pressure Yes <input type="checkbox"/> No <input type="checkbox"/>	Convulsions Yes <input type="checkbox"/> No <input type="checkbox"/>	Asthma Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Others</b>				

4. Antitetanus shot taken in the last six months	Yes <input type="checkbox"/>	No <input type="checkbox"/>
5. Has the child been hospitalized in the past year. If yes, provide details on a separate sheet.	Yes <input type="checkbox"/>	No <input type="checkbox"/>
6. Provide information of any muscle/ bone/ ligament related problems or recent fractures, if any	Yes <input type="checkbox"/>	No <input type="checkbox"/>
7. Does your child suffer from motion sickness?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
8. Does your child sleep walk or has a bed-wetting problem.	Yes <input type="checkbox"/>	No <input type="checkbox"/>

**9. Any other medical conditions, medical procedures / surgeries or ailments not covered above?**

Condition

10. Any Eye problems ?			
Ailment	Yes	No	Remarks
Distant Vision			
Near Vision			
Colour Vision			
Field of vision			
Right eye	SPH <input type="text"/>	CYL <input type="text"/>	Axis <input type="text"/>
Left eye	SPH <input type="text"/>	CYL <input type="text"/>	Axis <input type="text"/>

Name of the parent : \_\_\_\_\_

Signature of the parent

Date