Annexure 3

BAL BHARATI PUBLIC SCHOOL, DWARKA

MEDICAL FITNESS CERTIFICATE (2024-25)

Name of the child_____ Form No. _____

Date of Birth _____ Sex _____

Session _____ Class _____

Father's Name _____Telephone No. (Mobile)_____

Mother's Name _____Telephone No. (Mobile)_____

Residence Phone Number _____

Residential Address: _____

_____

Delhi_____

Office Address: Father-_____

Mother-_____

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	
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		

Name of the Child:_____ Sex: _____

Father's Name : _____ Mother's Name: _____

Father fully vaccinated against Covid? (Yes/ No)_____ Mother fully vaccinated against Covid? (Yes/ No) _____

Father's Signature:_____ Mother's Signature _____

Name of Doctor: _____

Signature of the Doctor: _____

Stamp of Doctor: _____

Date: _____