Annexure 3

BAL BHARATI PUBLIC SCHOOL, DWARKA

MEDICAL FITNESS CERTIFICATE (2025-26)

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 Doctor: ____________________________

Signature of the Doctor: ______________________________

Stamp of Doctor: ______________________________

Date: ________________________________