Circular for Immunization Records of students

D.A.V. PUBLIC SCHOOL
B-1, Vasant Kunj, New Delhi

Date: March 24, 2017

Subject: Verification of the Immunization Records of students in school affiliated to CBSE

Dear Parents

This is to inform you that CBSE has incorporated certain formats for verifying the record of immunization that a child has been subjected to. This is a mandatory compliance for CBSE. There are two formats of Health records provided by the Board.

1. **School Health Record** – One time submission (usually submitted at the time of admission) – a record of vaccinations and Health status.
2. **Student General Medical Check -Up**– To be submitted every year. It is more general and needs to be periodically updated to keep a record of the continuous Health status of the child through school.

As the school had not collected the medical history form at the time of admission, we require you to fill in both the given forms neatly and submit them by 15th July, 2017.

Regards,

Principal

D.A.V. PUBLIC SCHOOL
B-1, Vasant Kunj, New Delhi

School Health Record

General Information

Name:_____ _____ Date of Birth: …….	Admission No: …… Father's Mother /Guardian's Name & Address: _____ _____ _____ _____ Phone No. Office: …… Residence : …… Mobile: ……

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Name of the Student ..... M/F …….....Class.....

Date of Birth ..... Blood Group .....

Father's Name ……..... Mother's Name …….....

_____ VACCINATIONS _____

Immunization	Age Recommended	Due Date	Date
BCG	0-1 Month		
Hepatitis B	At Birth		
	1 Month		
	6 Month		
DPT	2 Months		
	3 Months		
	4 Months		
HB	2 Months		
	3 Months		
	4 Months		
Oral Polio	At Births		
	1 Months		
	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 age 1 year		
DT – OPA	4½ Year		

BOOSTER DOSES

Typhoid (every 3 years)			
TT (every 5 years)			
Other Vaccines			

Signature of Father …… Signature of Mother……

HEALTH HISTORY

ALLERGY TO ANY FOOD, ADHESIVE TAPE, BEE STING

Allergy	What Happened	How Severe	Medication Taken at the Time of Allergy

• Does the child have any problem during physical activity ……

Signature of Father ……..... Signature of Mother.....

To be certified by a Registered Medical Practitioner

Clinical Examination	Normal	Recommendation	
Head/Neck			
Abdomen			
Surgery			
Serious Illness			
Nails			
Skin			

Summary of Current Health Condition, _____

_____

_____

- Fit to Participate in age specific physical activity _____
- Fit to participate in age specific physical activity with precaution _____
  _____
- Should not participate in competitive sport _____

Signature of Doctor ……

Name of the Doctor……

……..												
General Appearance												
Weight Kg. Actual Percentile												
Height Cms Actual Percentile												
Eye Vision R. E.												
L. E.												
Squint Conjunctiva Cornea												
Rt. Lt. Ears : External Ear Middle Ear												
ORAL CAVITY GUMS Colour Teeth Occlusion Caries TONSILS Lymph Nodes												
Pulse												
B.P.												
Nails												
Skin												
Muscle, Skeletal System Knee/Flat Feet/Lordosis/Kyphosis												
Systemic Examination												

School Health Card – II

Name: _____Class_____

Age_____ Sex _____

Address:_____

Phone No: :_____

Blood Group:_____

The Major Parameters On Which The Annual Medical Checkups Done Are:

Dental _____

Eyes _____

General Cleanliness _____

Systemic Examination _____

Allergy (if any): _____

Date of Examination: _____

Past/Family History: _____

GENERAL:

Height: _____ Weight: _____

Nails: _____

Hair: _____

Skin:_____

Anemia: (Mild , Moderate, Severe or Absent)_____

Ear: _____

Nose: _____

Throat: _____

Neck: _____ _____ _____ _____ _____ _____ _____ _____

DENTAL EXAMINATION:

i. Extra-oral_____

ii. Intra-oral

a) Tooth cavity_____b) Plaque_____

c) Gum inflammation_____d) Stains_____

e) Tarter_____ f) Bad breath_____

g) Gum bleeding_____h) Soft tissue_____

SYSTEMIC EXAMINATION

Respiratory System: _____

Cardio vascular system _____

Abdomen: _____

Nervous System: _____

Eyes : _____

Right_____ Left_____

Important findings: _____

Remarks: _____

Medical officer's name and signature _____

Follow up : _____

_____

_____

Signature: _____ Date : _____

Designation: _____ Place : _____

Name: _____