



Pt. Deen Dayal Upadhyay Public School

AGRA ROAD MAINPURI, (U.P.) 205001, CONTACT:7500084100,9411250412



Session: 2024-25

MEDICAL EXAMINATION REPORT

Student's Name
(First Name) (Middle Name) (Surname)

Date of Birth Sex..... (Male/Female)

Emergency Contact

Person to call..... Relationship..... Mobile no.....

Address

Family doctor's name..... Mobile No.....

Blood Group.....Height..... Weight..... Vision.....

Allergies Epilepsy Asthma

Does your child have?

What is the reaction & treatment

If yes, please provide details

Is your child physically challenged? (Yes/No)

If "yes" please describe and attach any relevant information.....

Has your child ever had hearing difficulty? (Yes/No)

If yes, please mention.....

Has your child ever had vision problems? (Yes/No)

If yes, please mention.....

Hospitalization

Has your son/daughter been Hospitalized in the last 5 year? (Yes/No)

If so, for what reason

Does your child have a medical problem the school should know about?

Please describe

Is your child currently under medication/treatment.? (Yes/No)

Please indicate the type and purpose.....

