Bal Bharati PUBLIC SCHOOL ROHINI

MEDICAL FITNESS CERTIFICATE (2024-25)

Name of the child _____ Application No. _____

Date of Birth _____ Sex _____

Session _____Class _____

Father's Name _____

Telephone No (Residence) _____(Office) _____

Residential Address _____

_____ Delhi _____

Office Address _____

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	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		

Father's Signature: _____

Name: _____

Mother's Signature: _____

Name: _____

Name and Signature of Doctor:

_____

Stamp of Doctor:

_____