Bal Bharati
PUBLIC SCHOOL
ROHINI

MEDICAL FITNESS CERTIFICATE (2025-26)

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-

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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:

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Stamp of Doctor:

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