STUDENT HEALTH FORM

Assam Don Bosco University

Airport Road - Azara, Guwahati – 781017

(To be filled in by the student/parent)

A. Personal Details

NAME		**DATE OF BIRTH**	

B. Present Health

1. Is the student receiving medical treatment at present? Yes ☐ No ☐
   If yes, for what reason?

2. Does he/she take regular medications or in particular circumstances? Yes ☐ No ☐
   If yes, please give details below:

CONDITION	**MEDICATION**	**DOSAGE**	**WHEN TAKEN**

3. Does he/she have any known allergies? Yes ☐ No ☐
   If yes, please complete the following details:

ALLERGEN	**REACTION**	**TREATMENT**

C. Medical History

1. Please indicate (by ticking) whether he/she has suffered or has any of the following health problems. Please add any additional information that you feel is relevant.

Anaemia	Diabetes	High blood pressure	Meningitis	Thyroid disorder
Appendicitis	Hearing problem	Hysteria	Orthopedic problem	Tonsillitis
Asthma	Frequent nosebleeds	Insomnia	Recurrent headache	Tuberculosis
Chicken pox	Hemorrhoids	Kidney problem	Sleep walking	
Epilepsy	Hernia	Malaria	Speech difficulties	

2. Physical Disability

If he /she has a physical disability, would he/she require special assistance in the hostel? Please give details:

PARENT'S CONSENT

I hereby grant permission to administer First Aid and in the event of an emergency, if the parents/guardians cannot be reached, permission to take my ward to a hospital if deemed necessary.	Yes / No (please circle one)
I certify that all information given on this form is complete and correct *Signature of Parent/Guardian:*	 Date:

FITNESS CERTIFICATE

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(To be certified by a Licensed Physician/Medical Practitioner)

This is to certify that I have conducted a thorough physical/mental examination of ……
and find that he /she is in a fit state of physical and mental health to be enrolled at the University. He/she does not suffer from any infectious disease(s).

Height (cms)		Weight (Kgs)	
Blood Group & RH:			

Date:_____ Signature & Official Stamp _____

Name of the Licensed Physician/Medical Practitioner _____

Reg. No _____ Contact No. _____