MEDICAL FITNESS CERTIFICATE

Name				Date	of Birth		A	ge
Address								
								•••••
A. Family Health	-	•••••••••••	••••••••••			•••••	•••••••••••••	
	Age	History of hereditary diseases, communicable diseases & Mental illness, etc.				If Deceased		
	7.80					Date		Cause
Father								
Mother								
Brother								
Sister								
 Past illness: Tuber Disorders / Surgeries Physical Bowels Menstrual Periods Vision C. IMMUNIZATION	ardiac Diseases / Seizure disorder / Mental 3. Appetite 5. Sleep Frequency / Interval							
	Date	Result	Date	Result	Date	Result	Date	Result
BCG								
Tetanus Toxid								
TAB								
Hepatitis B								
Others								

D. MEDICAL EXAM	INATION							
Height	:		Weight	:		B.P.	:	
Nutritional Status	:		Posture	:		Skin	:	
Vision	:		Hearing	:		Dental	:	
C.V.S.	:		Respiratory System	:		GISystem	:	
Genito Urinary		Musculo Skeletal System:						
Endocrine System	:		Central Nervous Syst	em :				
E. LABORATORY FI	NDINGS :							
Blood:		Urine :			Faeces:			
X-ray:		Others :		Bloo	d Group :			
F. VISIBLE IDENTIFI	CATION	MARKS						
1.								
2.								
F. REMARKS:		Place (✓) Mark: Medically Fit (or) Unfit						
Place:								
Date : Name of the Doctor :								
Seal:								
		Signature & Qualification of the Medical Practitioner:						
		Reg. N	0. :					
		Addres	s :					

UNDERTAKING BY THE STUDENT & PARENT

My daughter/son is not suffering from any disease which will cause / interface / difficult to pursue this nursing course which warrants termination or dismissal from the college.

Signature of the Student

Signature of the Parent / Guardian

Date:

Place:

Note: If any student is found to be medically unfit, she / he will be asked to discontinue the course. If any existing illness detected subsequently, the student will face termination.