STUDENT HEALTH QUESTIONNAIRE

CONFIDENTIAL

This form should be completed by the parents or guardians and returned to the Admissions Office.

Student Particulars:

1. Name of student:
2. Year in which admission has been sought:
3. Age:
4. Blood Group:
5. Gender:
6. Height:
7. Weight:
8. Preference of food: Veg/ Non Veg

	Yes	**No**	**Comments if required**
Asthma			
Cardiac disorder			
Diabetes			
Gastrointestinal disorder			
Hearing disorder			
Hypertension			
Neuromuscular disorder			
Orthopaedic condition			
Respiratory illness			
Seizure disorder			
Skin disorder			
Visual disorder			
Other (please specify)			

PARTICIPATION IN SPORTS

	Yes	**No**	**Further comments if required**
Is the student presently taking any medication?			
Does the student suffer from respiratory ailments?			
Is the student on Asthma medication?			
Does the student wear contact lenses?			
Does the student suffer from migraine or recurrent headaches?			

Is there any other condition that we should know about?

A medical report from a doctor should be given for any medical condition not listed above.

We, the parents of …… understand that should any of the information given above found to be UNTRUE, the application for admission will be rendered null and void.

NAME OF FATHER: …….. SIGNATURE OF FATHER: ……

NAME OF MOTHER: …… SIGNATURE OF MOTHER: ……

DATE: ……..

NAME OF FAMILY DOCTOR: ……..

SIGNATURE: ……..