



**MEDICAL EXAMINATION RECORD  
FOR  
THE STUDENTS OF  
THE ASSAM VALLEY SCHOOL**

**Name:** .....

**Roll No.....House.....**

**GENERAL INSTRUCTIONS TO PARENTS/GAURDIANS:**

This medical examination form is to be used by the students of the Assam Valley School. The requirement to have a medical examination is a part of the conditions for the students of the Assam Valley School. The School has a 32 bedded hospital with choice for allopathic as well as homoeopathic treatment, 24x7 nursing care by excellent nursing staff. For any specialist opinion, the student is taken to the concerned specialist at Phulbari Central Hospital/Tezpur, at the student's expense. The details of the specialists are provided in the list at the end of the form. All treatment and medications in the School Infirmary are provided at cost to School while all expenditures on referrals (treatment outside the School), are billed to the parents of the concerned students.

The form contains the detailed medical examination report and is to be filled in by the concerned Specialists (Specialist may be from home town/city).

**PLEASE NOTE THE FOLLOWING CAREFULLY:**

1] It is important in both the child and School's interest that a true and detailed picture is given of the child's health.

2] Full details regarding treatment and investigations must be sent to the Resident Medical Officer (RMO) in the case of a child with a history of a) Bronchial Asthma b) Seizures c) Rheumatic Arthritis/Fever d) any other chronic illness. In the case of a child not responding satisfactorily to treatment, it may become necessary to request his/her withdrawal from the school.

3] Consultations with the specialist listed in Part-I are obligatory and should be completed before the child's departure for school.

4] If the child wears spectacles, it is imperative that he/she has 3 pairs- 1 for use, 1 to be deposited to the parent and 1 to be deposited at the School hospital.

5] The child must be duly immunized specifying dates in accordance with the requirements in this proforma. Phrases like "already done" will render this proforma incomplete.

6] This proforma must be completed and handed over to the RMO when the child returns back to School after winter vacations.

7] Please correspond directly with the RMO (at least a month in advance) regarding International Health formalities, if travel abroad is anticipated during the vacations.

8] The School cannot accept children who are suffering from any infectious skin diseases (e.g. ringworm, scabies, etc.). If an infectious skin disease is contracted during the holidays, please obtain treatment and a doctor's report, and inform the RMO about the same.

9] If your child is receiving any medication and returning to School, please ensure that the RMO is informed about the same and the entire course or supply of medicine is sent with them along with the prescription. It is then to be handed over immediately on arrival to the parent who will consult the RMO.

# STATEMENT TO THE MEDICAL PRACTITIONER

The bearer of this form is a student of the Assam Valley School. Each candidate is to be medically examined, by concerned specialist, for physical fitness. Your assessment and certification is to indicate whether the student is medically fit to undertake all activities of the School and list any medical disability or conditions which are likely to interfere with or be aggravated by any activity of the School.

## PART I

(To be filled in by the respective specialist)

### 1. Medical Specialist:

a) Height\_\_\_\_\_Weight\_\_\_\_\_Pulse\_\_\_\_\_BP\_\_\_\_\_RR\_\_\_\_\_

b) Systemic examination:

(i) General Appearance \_\_\_\_\_

(ii) Lymph Nodes: \_\_\_\_\_

(a) Ant. Cerv \_\_\_\_\_ (b) Post Cerv \_\_\_\_\_ (c) axill \_\_\_\_\_ (d) Ing \_\_\_\_\_

(iii) CVS \_\_\_\_\_ (iv) Respiratory Syst. \_\_\_\_\_

(v) Abdomen \_\_\_\_\_ (vi) C.N.S. \_\_\_\_\_

c) Menstrual History (Girls): \_\_\_\_\_

**Remarks:** This is to certify that \_\_\_\_\_ is mentally and physically fit.

Date: \_\_\_\_\_

\_\_\_\_\_  
(Signature & Official Stamp )

### (2) Pathologist :

#### Investigations:

(a) Blood:

(i) Hb \_\_\_\_\_ (ii) TLC \_\_\_\_\_ (iii) DLC \_\_\_\_\_

(iv) ESR \_\_\_\_\_ (v) Blood Sugar \_\_\_\_\_ (vi) S. Bilirubin \_\_\_\_\_

(b) Urine (R/E) \_\_\_\_\_

(c) Stool for Ova & cyst \_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
(Signature & Official Stamp )

### 3. Dermatologist (Skin) Specialist:

To r/o any infection of the:

(a) Scalp \_\_\_\_\_ (b) Face \_\_\_\_\_ (c) Neck \_\_\_\_\_ (d) Axilla \_\_\_\_\_

(d) Groin/Genitalia \_\_\_\_\_ (f) Toes \_\_\_\_\_

\_\_\_\_\_ (g) Nails \_\_\_\_\_

Remarks: \_\_\_\_\_

Date \_\_\_\_\_

\_\_\_\_\_  
(Signature & Official Stamp)

**4. ENT specialist :**

- (a) General Condition of Ears \_\_\_\_\_ (b) Hearing \_\_\_\_\_  
(c) Tympanic Membranes \_\_\_\_\_  
(d) Pharynx/Tonsils \_\_\_\_\_  
(e) Nasal Septum \_\_\_\_\_ (f) Adenoids \_\_\_\_\_

Date: \_\_\_\_\_  
\_\_\_\_\_  
(Signature & Official Stamp)

**5. Dental Surgeon (Dentist): AVS** now has a dental clinic and a visiting dental surgeon.

- (a) Oral Hygiene \_\_\_\_\_  
(b) General Condition of Gums \_\_\_\_\_  
(c) Caries \_\_\_\_\_  
(d) No. of fillings done (these must be completed during vacations) \_\_\_\_\_  
(e) For orthodontic treatment and follow-up, please discuss with the RMO in advance .

Date: \_\_\_\_\_  
\_\_\_\_\_  
(Signature & Official Stamp)

**6. Ophthalmologist (Eye Specialist):**

- (a) Acuity of Vision: (i) With Spectacles RE \_\_\_\_\_ LE \_\_\_\_\_  
(ii) Without Spectacles RE \_\_\_\_\_ LE \_\_\_\_\_  
(b) Conjunctiva \_\_\_\_\_ (c) Cornea \_\_\_\_\_  
(c) Fundoscopy \_\_\_\_\_

Date: \_\_\_\_\_  
\_\_\_\_\_  
(Signature & Official stamp)

**7. Surgical Specialist:**

(i) To r/o:

(a) Hernia \_\_\_\_\_ (b) Haemorrhoid \_\_\_\_\_

(c) Hydrocele \_\_\_\_\_

(ii) P/E of:

(a) Appendix \_\_\_\_\_ (b) P/R \_\_\_\_\_

(c) Genitalia \_\_\_\_\_

Remarks: \_\_\_\_\_

Date \_\_\_\_\_

( Signature & Official stamp )

**To be filled in by the Parent/ Guardian**

Allergic To : \_\_\_\_\_

During the vacation did your child:

a) Generally keep good Health \_\_\_\_\_

b) Suffer from any serious or debilitating illness e.g. Typhoid, Malaria, Infective Hepatitis, Rheumatic fever/Arthritis etc. \_\_\_\_\_

c) Undergo any surgery? \_\_\_\_\_

d) Sustain any serious injury or fracture? \_\_\_\_\_

e) Manifest with any allergy? Elaborate on type of allergy and suspected/known cause. \_\_\_\_\_

f) Suffer from Bronchial Asthma, if so when was the last attack? \_\_\_\_\_

**Consent:-**

I consent to any form of surgery/treatment for my child, which in the option of the school Authorities, is deemed necessary. I authorize the school to sign on my behalf. The entire expenses will be borne by me. This remains valid throughout the stay of my child in this school.

Date: \_\_\_\_\_

\_\_\_\_\_  
Signature of the Parent/Gaurdian

Name and full address \_\_\_\_\_

Telephone No \_\_\_\_\_

Name, Address and Tel. No. of 2 alternative person in case of an emergency (Preferably in Tezpur, Guwahati or Jorhat).

1. \_\_\_\_\_

2. \_\_\_\_\_

**PART II**

**8.Immunization: (only new immunization or booster dose given during vacation)**

(a) T.A. i.e. Typhoid/Para-Typhoid A (or A.KD. for under 12 yrs. valid for 3 yrs.)

Date \_\_\_\_\_

(b) T.T. (i.e. Tetanus Toxoid valid for 4 yrs.)

Date \_\_\_\_\_

d) Chicken pox(Varicella) vaccine:

Date: \_\_\_\_\_

(c) Hepatitis-B:

Date: \_\_\_\_\_ Dose-1

Date: \_\_\_\_\_ Dose-2

Date: \_\_\_\_\_ Dose-3

(e) Hepatitis- A:

Date: \_\_\_\_\_ Dose-1

Date: \_\_\_\_\_ Dose-2

**CONSENT TO HOMEOPATHIC SYSTEM OF TREATMENT:**

The School hospital also has homeopathic system of treatment offered by qualified consultant. Please indicate if you agree/disagree to this system of treatment for your child.

YES/NO

\_\_\_\_\_  
(Signature of parent/guardian)

**LIST OF SPECIALISTS AT PHULBARI CENTRAL HOSPITAL/ TEZPUR**

**SURGERY:**

1) Dr. P Barman PCH  
2) Dr. M Majid & (3) Dr Sanjay Singh TEZPUR

**MEDICINE:**

1) Dr. D Das PCH  
2) Dr (Mrs) D R Baruah & (3) Dr. B Bhuyan TEZPUR

**ENT**

1) Dr. (Mrs) M. Barman PCH  
2) Dr. S P Bordoloi TEZPUR

**EYE :**

1) Dr. (Mrs) A Dowerah PCH  
2) Dr M. Tamuli & (3) Dr(Mrs) C Deka TEZPUR

**GYNAECOLOGY:**

1) Dr. K. Dowerah &(2) Dr. (Mrs.) N Deka PCH  
3) Dr. M. Mirdha TEZPUR

**DENTAL :**

1) Dr. (Mrs.) A. Das PCH  
2) Dr. P.K. Sharma TEZPUR

**ORTHOPAEDICS:**

1) Dr S Bora & ( 2) Dr D Deka TEZPUR

**SKIN:**1) Dr B K Nath TEZPUR