



# St. Mary's High School, Mt. Abu

## HEALTH PROFILE 2026

*Kindly note that for the safety of all concerned a recent medical report, not older than three days prior to the date of joining school, needs to be submitted.*

Class:  Child's Name:  Age:   
Blood Group:

B.NO.:

a) EYE SIGHT: ☐ Normal Vision ☐ Suffers from:

Last checked on:

Follow up action required (if any)

b) DENTAL: ☐ No problems ☐ Suffers from:

Last checked on:

Follow up action required (if any)

c) E N T: ☐ No problems ☐ Suffers from:

Last checked on:

Follow up action required (if any)

d) RESPIRATORY SYSTEM: ☐ No problems ☐ Suffers from:

Last checked on:

Follow up action required (if any)

e) GASTRO - INTESTINAL SYSTEM: ☐ No problem ☐ Suffers from:

Last checked on:

Follow up action required (if any)

f) UROGENITAL SYSTEM: ☐ No problems ☐ Suffers from:

Last checked on:

Follow up action required (if any)

g) SKIN: ☐ No problems ☐ Suffers from:

Last checked on:

Follow up action required (if any)

h) CENTRAL NERVOUS SYSTEM: ☐ No problems ☐ Suffers from:

Last checked on:

Follow up action required (if any)

i) ALLERGIES: ☐ No problems ☐ Suffers from:

Last checked on:

Follow up action required (if any)

### NOTE.

**Parents are requested to submit Medical Reports or Authorized Reports [Photo - Copy] along with the Form duly signed or prescribed by a Registered Medical Practitioner.**

**P.T.O**

1] Has your Child ever had an Operation, Accident or Serious injury?  
[If Yes, briefly state its nature.]



2] Does your Child have any medical condition that the school needs to be aware of?  
[If Yes, state the nature of the condition.]

3] Does your Child need to be exempted from any School Activity like Sports/Swimming etc.?  
[If Yes, specify the activity that he needs to be exempted from and the reason.]

4] Is your Child under any regular medication?  
[If Yes, kindly attach the prescription and state the condition that requires such medication.]

5] How would you best describe the general health of your Child?

6] Has your child ever tested positive for COVID 19? [YES/NO] If Yes, kindly mention the date.

### VACCINATIONS

Kindly give your Child the following Vaccinations if he has not yet taken them: [Including Booster if and when they are due with respective certificate]

VACCINATION		Date Given On	Remark [if Any]
TYPHOID	[Boosters every 3 years]		
TETANUS	[Boosters every 5 years]		
1. HEPATITIS A			
2. HEPATITIS B			
3. CHICKEN POX			
4. MMR			
5. INFLUENZA [For Bronchial Asthma]			
6. TYPHOID			
7. TT BOOSTER			
8. H1N1			

Stamp and Seal of the Medical Practitioner

Signature of Parent

Signature of Registered Medical Practitioner