Shuvatara Day cum Residential School

Mahalaxmi Municipality
Ward No. 9
Lamatar, Lalitpur
Phone: 5132070, 5132169
E-mail: shuvainfo@yahoo.com, shuva.lamatar@gmail.com

Please attach one recent passport size photograph. (B/W or Colour)

STUDENT MEDICAL DATA

Form No:_____

The following information is requested so that the school and parents can work together to better meet the physical, intellectual and emotional needs of the child in the school. Please submit these with the application form.

Child's Full Name:_____ Sex: ☐ Male ☐ Female
Surname *Middle name* *First name*

Date of Birth (Please attach birth certificate)

Date		Month		Year	
					A.D
					B.S

Height _____
Weight _____

Blood Group: Please attach pathologist's blood report slip: ☐

Please tick if applicable and supply extra comments :

- ☐ Eyesight - Normal/not Normal
- ☐ Hearing- Normal/not Normal
- ☐ Speech - Normal/not Normal
- ☐ Problem in concentration
- ☐ Problem with memory/retention
- ☐ Problem with behavior/discipline/attitude
- ☐ Anger Management Issue/Temper/Tantrams
- ☐ Seizures or attacks
- ☐ High fevers
- ☐ Pre or Menstrual problems _____
- ☐ Appetite - Normal/excessive
- ☐ Substance abuse
- ☐ Nail biting and other nervous tendencies
- ☐ Travelling sickness
- ☐ Disturbed Sleep
- ☐ Hyper activity
- ☐ Nasal Bleeding
- ☐ Persistent colds, cough
- ☐ Persistent headaches / stomach aches
- ☐ Bed wetting
- ☐ Sleeping difficulties
- ☐ Problem in physical coordination
- ☐ Over thirstiness
- ☐ Headaches

Do these problems recur now ? Yes ☐ No ☐

Specify which problem _____

How often do they occur _____

Updated Immunization Record

- ☐ Diphtheria 1st
- ☐ Pertussia 2nd
- ☐ Tetanus 3rd
- ☐ Meningitis

Boosters

- ☐ Tetanus
- ☐ Diphtheria

Boosters

- ☐ Polio Oral
- ☐ Polio injection

Has your child suffered from any of these diseases/conditions to the extent of becoming chronic?

Tick ✓ if yes ✗ if negative

	When?		When?
☐ Thyroid Deficiency	_____	☐ Liver disease	_____
☐ Heart problem	_____	☐ Tonsillitis	_____
☐ Lung problem	_____	☐ Sinuositis	_____
☐ Urinary diseases	_____	☐ Dental problems	_____
☐ Diabetes	_____	☐ Digestive disorders	
☐ Rickets	_____	☐ Loose motion, constipation, dysentery etc.	_____
☐ Tuberculosis	_____	☐ Other ailments/diseases	_____
☐ Low or high blood pressure	_____	☐ Chicken pox/Typhoid/Measles etc.	_____

Do any of these problem recur now?
☐ Yes ☐ No

Specify which problem and how often ?_____

_____

Does your child have any Dermatitis? (skin problem like rashes, scabies, etc.) ☐ Yes ☐ No

What type ?_____

If yes then please specify methods we should adopt for emergency treatment: _____

_____

Does your child have allergies (Due to dust, water, grass, food and clothing, allergies, etc.) ☐ Yes ☐ No

What type?_____

If yes, then please specify methods for emergency treatment:_____

Food drinks to be avoided:_____

Medicines to be avoided:_____

Is your child left handed: ☐ Yes ☐ No Uses both hands: ☐ Yes ☐ No

Does your child use any regular medications ☐ Yes ☐ No Please specify _____

When has your child last been de-wormed ? Please Specify when :_____

Was the de-worming effective? ☐ Yes ☐ No Comments _____

Can we give the following drugs/medications to your child? Should he/she need it under medical supervision ?

Please specify	**Yes you may**	**No you may not**
Antibiotics	_____	_____
Antibiotic cream / spray	_____	_____
Antihistamines	_____	_____
Anti diarrhoeals	_____	_____
Paracetamol	_____	_____
Painkillers	_____	_____
Aspirin	_____	_____
Saline if required	_____	_____
Blood if required	_____	_____
Light sleep inducers	_____	_____

Drugs to be used/avoided if any:_____

_____

Doctors to be consulted if any: _____ Phone No._____

Tests to be done if any: _____

Conditions to be watched :_____

Are there any factors related to the child's overall development which you want us to know about?

_____

_____

Parents Signature:_____

Date : _____

Phone No : _____

Doctor's Signature:_____

Name : _____

NMC No : _____

Phone No : _____