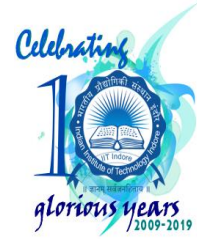




INDIAN INSTITUTE OF TECHNOLOGY INDORE

MEDICAL FITNESS FORM
E-mail: healthcentre@iiti.ac.in
Contact: +91 (0)0731-6603571

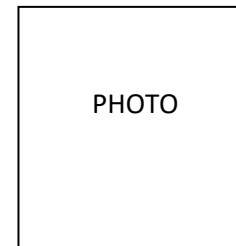


TO BE SUBMITTED TO HEALTH CENTRE DURING ENROLLMENT AT IIT INDORE

MEDICAL FITNESS CERTIFICATE (To be issued by a Registered Medical Practitioner)

PERSONAL HISTORY

- 1. Name
- 2. Parent/ Guardian’s Name.....
- 3. Age Years Months
- 4. Sex.....
- 5. Identification Mark on the Body, if any (This can be a mole, scar or birthmark)
- *6. Course of Study and Roll No.
- *7. Insurance No



*** To be filled at the time of enrollment**

CERTIFICATE

(The following are to be filled by a Registered Medical Practitioner conducting the medical examination)

- 1. **Height**cm
- 2. **Weight** Kg
- 3. **Significant History and Examination findings:**
 - a) Food or medicine allergy: Yes No If any, kindly specify.....
 - b) Bronchial Asthma
 - c) Epileptic Fit
 - d) Psychiatric Illness.....
 - e) Tuberculosis (T.B.): Newly diagnosed case Under treatment since..... months Completed treatment in
 - Treatment details if any..... Has past history of tuberculosis

f) I have examined the person thoroughly and there is no evidence of tuberculosis .

g) Major illness/ surgery, if any (Specify nature of illness/ surgery)

h). Were you diagnosed with Covid 19? If yes, When?

i) Any other significant history

4. **Blood Group**

5. Chest

a) Inspirationcm

b) Expirationcm

6. **Hearing**.....

7. Vision with or without glasses

a) Right Eye..... b) Left Eye.....

c) Colour Blindness: Yes No d) Any other problem

8. **Respiratory system**

9. **Nervous system/Any psychological disorder**-.....

10. **Cardiovascular System**.....

a) Sounds..... b) Murmur

11. Abdomen

a) Liver..... b) Spleen

12. a) Hernia b) Hydrocele

13. Any other illness

Certified that...

I have examined.....
Son/daughter ofthoroughly and have found that he/she is
having...../ he/she is in sound health to pursue
his/her studies at IIT Indore.

Signature of the Medical Officer

Date:

Name/Registration No.

Official Seal

Signature of the Candidate

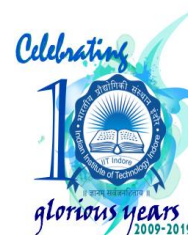
Date.....

Full Name.....



INDIAN INSTITUTE OF TECHNOLOGY INDORE

MEDICAL FITNESS FORM



Health Centre

Date: _____

All students * should receive following vaccinations prior to admission.

A. Vaccination Certificate:

Name of Vaccine	Date of Vaccine	Doctor's Signature
Typhoid		
Hepatitis A		
MMR (one dose after 15 years of age is essential)		
Chickenpox(If there is no history of chickenpox in past)		
Covid 19		

B. Vaccination Exemption Certificate:

Mr./Ms _____ is suffering from _____
and is on _____ treatment. Hence, vaccination is contraindicated in him/her.

Registered Medical Practitioner

* Only those students in whom vaccination is medically contraindicated will be exempted from these vaccinations on provision of medical certificate by registered medical practitioner.
