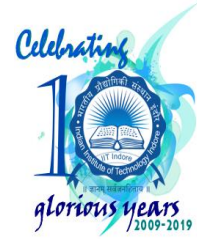




INDIAN INSTITUTE OF TECHNOLOGY INDORE

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.....

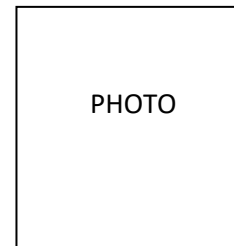
5. Identification Mark on the Body, if any (This can be a mole, scar or birthmark)

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

*7. Course of Study and Roll No.

*8. 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. Past History

a) Allergy/ Bronchial Asthma

b) Epileptic Fit

c) Psychiatric Illness.....

- d) Tuberculosis
- e) 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 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.....

Son/daughter of is in sound physical health to pursue his/her studies at IIT Indore.

Signature of the Medical Officer

Date:

Name/Registration No. and Official Seal

Signature of the Candidate

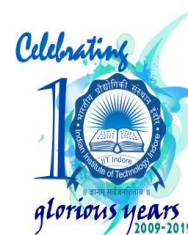
Date.....

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)		

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.
