भारतीय प्रौद्योगिकी संस्थान इंदौर
खंडवा रोड, सिमरोल, इंदौर, 453552, भारत
INDIAN INSTITUTE OF TECHNOLOGY INDORE
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FILLED AND CERTIFIED FORM TO BE SUBMITTED TO HEALTH CENTRE DURING ENROLLMENT AT IIT INDORE

MEDICAL FITNESS CERTIFICATE (from a Registered Medical Practitioner)

PHOTO

PERSONAL DETAILS

1. Name ……..……..…

2. Name of parents/Guardian……

Contact number of parents/Guardian……....

3. Age ……..……. Date of birth ….……. 4. Gender …….

5. Contact No. ..…….. Emergency Contact No. ……..

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

7. Course of Study and Roll Number (To be filled at the time of enrollment)

……..

CERTIFICATE

1**. Height** ……cm **Weight** ……. Kg **Blood Group** …….

2**. Pulse rate……..** **Blood pressure ……**

3**. Significant history and examination findings: Please complete all details**

- 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 a past history of tuberculosis ☐ Yes ☐ No
  I have examined the person thoroughly and there is no evidence of tuberculosis.

- f) Major illness/ surgery, if any …….……
  (Specify nature of illness/ surgery)
- g) Any other significant history …….

4**. Respiratory System: Any significant findings ……...**

…….

a) Inspiration ……cm b) Expiration …….cm

5**. Ear, Nose, Throat** …….

Hearing: Right Ear……Left Ear…….

6**. Vision with / without glasses**

- Right Eye……. b) Left Eye……...……
- c) Colour Blindness: ☐ Yes ☐ No d) Any other problem ….....

7. **Nervous system**/Any psychological illness: **……**

……

8**. Cardiovascular System**: Sounds…….b) Murmur …….……

9. **Gastrointestinal system**: …….

Abdomen **-** a) Liver…….. b) Spleen ……..……..

10**. Genitourinary system**:……

Hernia ……. b) Hydrocele ……

11. **Infectious / Communicable diseases**……

12. Any other illness / On regular treatment for any illness, If yes, please provide details ……..

Certified that…

I have examined Mr/Ms ……. Son/daughter of ……...……..…… thoroughly 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 /Consultant **Date:**
Name and Registration No. …… Official Seal
Signature of the Candidate:
Date...…….
Full Name…….....

INDIAN INSTITUTE OF TECHNOLOGY INDORE

MEDICAL FITNESS FORM

Date: _____

All students should receive the following vaccinations prior to reporting to IIT Indore for admission.

A. VACCINATION CERTIFICATE:

Sr No.	Name of vaccine	Date of Vaccination and Batch number/sticker of name & batch number of vaccine	Doctor's Signature With Stamp
1	**Typhoid** (one dose after 15 years of age is essential)		
2	**Hepatitis A** (One dose after 15 years of age is essential, if there is no past history of Hepatitis A)		
3	**MMR** (one dose after 15 years of age is essential)		
4	**Chickenpox** (One dose after 15 years of age is essential, if there is no past history of Chickenpox)		

B. Vaccination Exemption Certificate:

Mr./Ms _____is suffering from _____and is on_____treatment. Hence, vaccination is contraindicated in him/her.

Date: _____

Signature of Registered Medical Practitioner
Office seal with name, registration number

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