



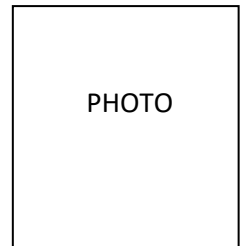
भारतीय प्रौद्योगिकी संस्थान इंदौर  
खंडवा रोड, सिमरोल, इंदौर, 453552, भारत  
INDIAN INSTITUTE OF TECHNOLOGY INDORE  
Khandwa Road, Simrol, Indore, 453552, India  
Contact No. 0731-660-3571/3187

**FILLED AND CERTIFIED FORM TO BE SUBMITTED TO HEALTH CENTRE  
DURING ENROLLMENT AT IIT INDORE**

**MEDICAL FITNESS CERTIFICATE (from a Registered Medical Practitioner)**

**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**

Name and Registration No. ....

**Signature of the Candidate:**

Date.....

Full Name.....

**Date:**

Official Seal



## **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:**

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