



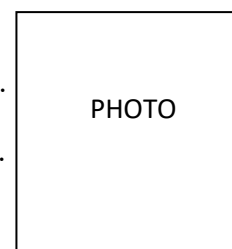
भारतीय प्रौद्योगिकी संस्थान इंदौर
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INDIAN INSTITUTE OF TECHNOLOGY INDORE
Khandwa Road, Simrol, Indore, 453552, India
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FILLED AND CERTIFIED FORM TO BE SUBMITTED TO HEALTH CENTRE DURING
ENROLLMENT AT IIT INDORE

MEDICAL FITNESS CERTIFICATE (To be issued by 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. Identification Mark on the Body, if any
(This can be a mole, scar or birthmark)
6. Course of Study and Roll Number (To be filled at the time of enrollment)
.....



CERTIFICATE

1. Heightcm Weight Kg Blood Group
2. Pulse rate/minute..... Blood pressure
3. Significant history and examination Findings: : Please complete all details including treatment details, if any.

- 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 ☐ Yes ☐ No

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

- f) Hypertension Y ☐ N ☐ If Yes, Treatment details.....
- g) Diabetes Mellitus: Y ☐ N ☐ If Yes, Treatment details.....
- h) Cardiac disease if any Y ☐ N ☐ If Yes, ailment.....
Treatment details.....
- i) Kidney disease: Y ☐ N ☐ If Yes, ailment.....Treatment details....
.....
- j) Any Neurological disease: If Yes, ailment.....Treatment details.....
- k) Significant infectious disease, if any provide details.....
- l) Major illness/ surgery, if any
(Specify nature of illness/ surgery)
- m) Any other significant history

4. Respiratory system: Any significant findings
.....

Inspirationcm ,

Expirationcm

5. Ear, Nose, Throat : Any significant findings
.....

Hearing: Right Ear.....Left Ear.....

6. Vision with or without glasses

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

7. Nervous system/Any psychological disorder: Any significant findings:
.....

8. Cardiovascular System: a) Sounds.....b) Murmur

9. Gastrointestinal system:

a) Liver..... b) Spleen

10 Genitourinary system:

a) Hernia b) Hydrocele

11. Any other illness:
.....

12. X-Ray Chest PA view (Please submit X-ray film and report with form.)

13. Urine Routine analysis report.....

14. HIV test report.....

15. Routine blood analysis including complete blood count, blood glucose, serum creatinine, Liver enzymes-ALT, AST

(Please submit all reports with the form)

16. Any other test deemed fit by registered medical practitioner to rule out chronic illness

.....

Certified that...

I have examined Mr/Ms
Son/daughter ofthoroughly and have found that

1. This applicant **IS / IS NOT** physically able to carry on a full course of study, involving long hours of work, in a college or university in India.

2. In my opinion the applicant's health and physical condition in general are:

Excellent ☐

Good ☐

Poor ☐

3. I certify that the applicant is up-to-date on routine vaccinations including, among others, MMR, DPT, Typhoid, Varicella, Hepatitis A & B etc.

4. He / She has no physical condition/ailment which would hinder him/ her from pursuing a full course of study in India. _____ ()

5. He / She present no evidence of any communicable disease or of any chronic fatigue.
_____ ()

6. He / She has no chronic medical condition requiring regular and sustained medical treatment. _____ ()

Signature of Physician / Senior Consultant

Name/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:

Sr. No.	Name of Vaccine	Date of Vaccination /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./Msis suffering from.....
and is ontreatment since
Hence, vaccination is contraindicated in him/her.

**Signature of Registered Medical Practitioner
with name, registration number and Office Seal**

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