भारतीय प्रौद्योगिकी संस्थान इंदौर
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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 (To be issued by a Registered Medical Practitioner)

PERSONAL DETAILS

PHOTO

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**. Height** ……..cm **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 ……...**
……

Inspiration ……cm , Expiration …….cm

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 of ……..……thoroughly 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 **Date:**
Name/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 /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 ye ars 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 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.