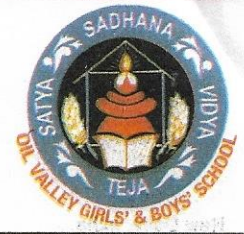


# Oil Valley Girls' & Boys' School

## DIBRUGARH



### Physical Fitness Report Form for Day Boarder / Boarder

**NOTE : PLEASE USE BLOCK LETTERS TO COMPLETE THIS FORM**

All questions **MUST** be answered honestly, please submit to Resident Officer at the time of admission

SURNAME	<table border="1" style="width: 100%; height: 20px;"> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </table>																																										
FIRST NAME	<table border="1" style="width: 100%; height: 20px;"> <tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </table>																																										
DATE OF BIRTH	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>	<table border="1" style="width: 20px; height: 20px;"></table>																					
	DD	MM	YY		SEX	MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>																																				

Next of kin information : .....

Name : .....

Address : .....

ISD code	/	country code	/	area code	/	local number
<table border="1" style="width: 100%; height: 20px;"></table>		<table border="1" style="width: 100%; height: 20px;"></table>		<table border="1" style="width: 100%; height: 20px;"></table>		<table border="1" style="width: 100%; height: 20px;"></table>

Emergency Phone No. :

E-mail : ..... Fax : .....

### Medical History Form ( Part I )

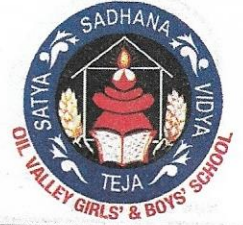
SL. NO.	QUESTION	Date	RESPONSE Remarks
1	Has your ward had any of the following Childhood diseases ? (a) Chicken Pox (b) Measles (c) Mumps (d) Diphtheria (e) Whooping Cough (f) Polio	<table border="1" style="width: 100%; height: 20px;"></table>	<table border="1" style="width: 100%; height: 20px;"></table>
		<table border="1" style="width: 100%; height: 20px;"></table>	<table border="1" style="width: 100%; height: 20px;"></table>
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		<table border="1" style="width: 100%; height: 20px;"></table>	<table border="1" style="width: 100%; height: 20px;"></table>
2	Has he / she suffered from any of the following other diseases ? (a) Tuberculosis (b) Enteric (Typhoid ) Fever (c) Dysentery	<table border="1" style="width: 100%; height: 20px;"></table>	<table border="1" style="width: 100%; height: 20px;"></table>
		<table border="1" style="width: 100%; height: 20px;"></table>	<table border="1" style="width: 100%; height: 20px;"></table>
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# Oil Valley Girls' & Boys' School

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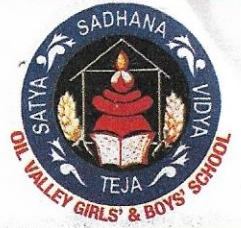
3	(d) Malaria		
	(e) Dengue Fever		
	(f) Rheumatic Fever		
	(g) Infective Hepatitis (Jaundice)		
	(h) Mononucleosis		
	(i) Other disease / illness if any		
4	Does / did he / she suffer from any ENT ? problems ?		
	(a) Frequent colds		
	(b) Frequent nosebleeds		
	(c) Frequent sore throat ( Tonsillitis )		
	(d) Any symptoms of deafness		
	(e) Tooth or Gum problems		
	(f) Hay Fever / allergies		
5	Does / did he /she suffer from any Chest or respiratory problems ?		
	(a) Rheumatic Heart disease		
	(b) Other Heart problems		
	(c) High Blood Pressure		
	(d) Haemophilia ( excessive bleeding )		
5	Does / did he /she suffer from any GI / GU conditions ?		
	(a) Appendicitis		
	(b) Abdominal pain		
	(c) Bladder / Urinary infection		
	(d) Diarrhoea / dysentery		
	(e) Gall Bladder		
	(f) Frequent indigestion		
	(g) Haemorrhoids		
(h) Hernia			



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6	(i) Kidney infection Does / did he /she suffer from any Skin conditions ? (a) Eczema (b) Impetigo (c) Frequent boils (d) Scabies		
7	Does / did he /she suffer from any Neurological conditions ? (a) Convulsions / Epilepsy / Fits (b) Dizziness / Fainting spells (c) Vertigo (d) Frequent headaches (e) Neuritis		
8	Does / did he /she suffer from any Other medical conditions ? (a) Insomnia (b) Sleep Walking (c) Depression (d) Hysteria (e) Mental illness (f) Psychiatric treatment		
9	Has he / she had any surgical operation, head or other serious injury, or fracture of the bones ? If so, please give particulars.		
10	Is he / she a bed-wette ? If so, how frequently does this happen ?		
11	Has he / she been X-rayed at any time ? If so, when and for what ?		
12	Are his / her eyes and eyesight normal ?		

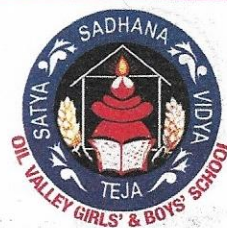
**APPLICATION PACK**



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13	Does he / she wear glasses or contact lenses (if yes, attach prescription) or suffer from any other eye ailment ?		
14	Are his / her teeth generally in good order ?		
15	Does he / she need orthodontic treatment ?		

**Medical History Form (Part II)**

Height :            Cm	Weight :            Kg	Temp :	Pulse :	B.P. :
Chest ( full expiration ) :		Chest ( full inspiration ) :		
Blood Group & RH :		Blood & WBC : Hgb-grams%		
Montoux Test ( if done ) : Positive / Negative				
Pathology ( Blood, urine & stool, if applicable ) :				
Skin conditions :				
Eyes / Vision (attach prescription if glasses or contact lenses are worn )				
Ears / Hearing				
State of appendages / extremities				
State of Spine & Neck, Posture :				
Signs of flat feet or other defects				
Breasts				
Glands				
Throat / Tonsils				
Piles / Fissure				
Abdomen / Hernia / Spleen				
Pelvo-Rectal				
Cardio Vascular System				
Respiratory System				
Neurological / Central Nervous System				

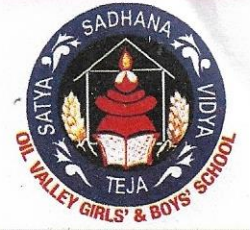
**APPLICATION PACK**



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**DIBRUGARH**



IMMUNISATION RECORD	PRIMARY (DD, MM & YY)	BOOSTER (DD, MM & YY)
BCG		
POLIO		
DPT		
MEASLES		
MMR		
TETANUS TOXOID		
TABC		
TYPHOID		
HEPATITIS 'A'		
HEPATITIS 'B'		
OTHERS		

This is to certify that I have conducted a through medical examination of .....  
and find that he / she is in a fit state of physical and mental health to join a residential school and does not suffer from any infectious disease. He / she (tick one) .....is / ..... not permitted to participate in games and physical education activities.

Remarks / Restrictions : .....

.....

.....

Date .....

Signature & Stamp of Medical Practitioner

Regd No .....

Name of Medical Practitioner .....

Address .....

.....

.....

Contact No . (Off) : .....

Contact No. (Res) : .....