The Lillian School

Rise & Shine for GOD

MEDICAL REPORT FORM

Date:____/ ___/ _____

Name of the Child : _____

Standard : _____

Date of Birth : _____/_____/_____Gender : _____

DD MM YY

Blood Group : _____ Height : _____cms. Weight :_____Kgs

For Immunization Record : (Please tick below) :

☐ OPV ☐ Measles ☐ BCG ☐ OPT ☐ MMR ☐ Hepatitis B

Tuberculosis Screening : ☐ Negative ☐ Positive

If yes whether on Anti TB Treatment : ☐ Yes ☐ No

ENT Check Up Details : _____

Eye Check Up Details : _____

Major illness in the past : _____

Hospitalizations in the past : _____

Any Continuous Medication : _____

Any Other Sickness (Asthma, Allergies etc.) : _____

Any Physical Disability (If yes please specify) : _____

Any Learning Disability (If yes please specify) : _____

Present Physical Status : _____

Panel of Doctors :

1. Dr. Name, Stamp & Sign of Doctor

Name:

2. Dr. Stamp:

3. Dr.

Signature : _____