MEDICAL EXAMINATION REPORT - 2024
(To be issued by a Class ‘A’ Registered Medical Practitioner)

PERSONAL HISTORY

1. Name : ..……
2. Registration No : ..……
3. Branch : ..……
4. Parent / Guardian’s Name : ..……
5. Age : ……Years……..…Months
6. Sex : ……..
7. Identification Mark of the Body, if any: ……
   ( This can be a mole, scar or birthmark )
8. Major illness/ operation, if any : ……
   ( Specify nature of illness /operation )

MEDICAL CERTIFICATE

( The following are to be filled by the Class ‘A’ Registered Medical Practitioner conducting the medical examination)

1. Height……..cm
2. Weight……..…kg
3. Past History
   a) Mental Disease……
   b) Epileptic Fits……
4. Chest
   a) Inspiration……cm
   b) Expiration……cm
5. Blood Group……..
6. Hearing…….
7. Vision with or without glasses
   a) Right Eye…….
   b) Left Eye……
   c) Colour Blindness…….
   d) Uniocular Vision……..
8. Respiratory system……
9. Nervous system…….
10. Heart
    a) Sounds……..
    b) Murmur……
11. Abdomen
    a) Liver……...
    b) Spleen……
12. a) Hernia…….
    b) Hydrocele……
13. Any other defects……..

Certified that…….son/daughter of…….

**Please put Tick Marks**

a) fulfills the prescribed standard of physical fitness and is FIT for admission to IIST.

b) does not fulfill the prescribed standard of physical fitness and is unfit temporarily unfit for admission due to following defects.

Signature of the Medical Officer Signature of the Candidate

Full Name……..

Medical Registration No……

Date…….

Hospial/Office Seal

**Instructions to students regarding medical procedure at the time of admission to IIST**

GENERAL EXPECTATIONS

Candidates should have good general physique, in particular,

a) Chest Measurement should be not be less than 70 cm, with satisfactory limits of expansion and contraction
b) Vision should be normal. In case of defective vision, it should be corrected to 6/9 in both eyes or 6/6 in the better eye.
c) Hearing should be normal. Defective hearing should be corrected.
d) Heart and lungs should not have any abnormality and there should be no history of mental disease or epileptic fits.
e) **Should undergo immunization schedule in full and furnish the certificate in the enclosed format signed by Civil Surgeon/Medical Officer of a Government Hospital**.

RECOMMENDED VACCINATION SCHEDULE

1) Varicella ( Chicken Pox )

For those who have not had Chicken Pox or the vaccine, 2 doses of the vaccine with an interval of 4 weeks between the doses.

2) Measles, Mumps and Rubella :

Adolescents who did not receive the two-shot course of MMR vaccine, should receive 2 doses 4 weeks apart.

**CERTIFICATE OF VACCINATION**
(TO BE SUBMITTED AT THE TIME OF JOINING)

<table>
<tr><th>Name of Vaccine</th><th>Date of Vaccination</th><th>Doctor's Signature along with seal</th></tr>
<tr><td>MMR</td><td></td><td></td></tr>
<tr><td>Chickenpox</td><td></td><td></td></tr>
<tr><td rowspan="4">Covid-19</td><td>Date of 1st dose</td><td rowspan="4">Vaccine Name:<br><br>(Attach Vaccination Certificate)</td></tr>
<tr><td></td></tr>
<tr><td>Date of 2nd dose</td></tr>
<tr><td></td></tr>
</table>

Place: Signature of the candidate

Date :

## छात्र और उनके माता–पिता द्वारा प्रस्तुत की जाने वाली घोषणा जिसमें छात्र के एलर्जी या अन्य बीमारियों से पीड़ित होने तथा ली जा रही दवाइयों का विवरण है।

## DECLARATION TO BE SUBMITTED BY THE PARENT AND STUDENT REGARDING DISEASES/ALLERGIES SUFFERED & MEDICINES BEING ADMINISTERED BY THE STUDENT

मैं एतद्वारा घोषित करता हूं /करती हूँ कि मेरा पुत्र / पुत्री श्री / कुमारी ....., छात्र पहचान संख्या ....., स्नातक कार्यक्रम ....., निम्नलिखित एलर्जी या अन्य बीमारियों से पीड़ित है और उन्हें नीचे उल्लिखित दवाइयां दी जा रही हैं।

I hereby declare that my son/daughter Shri./Ms ..... of Undergraduate Course in..... SC No. ..... is suffering from following allergies/ diseases and the given medicines are being administered.

| क्रम सं. Sl No. | एलर्जी या अन्य बीमारियों का नाम / Name of allergies/ diseases | दवा का नाम / Name of the medicine | दवा की कीमत - प्रति गोली / प्रति बोतल Price of the medicine per tablet/ per bottle etc | दवा लेने का प्रयोजन Purpose for administering the medicine |
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माता-पिता/अभिभावक के हस्ताक्षर / Signature of the parent/guardian :

माता-पिता/अभिभावक का नाम / Name of the parent/guardian :

छात्र के हस्ताक्षर / Signature of the student :

छात्र का नाम / Name of the student :

तारीख / Date :