The Lawrence School
Sanawar
MEDICAL PROFORMA
(TO BE FILL BY STUDENTS WHO ARE ALREADY IN THE SCHOOL)

You are requested to have this certificate completed and returned by 20th February, directly to the House Master/ Mistress. Kindly do not post these directly to the Hospital .

It is in the interest of the child and the School that a true and detailed picture is given of the child's health.

Part-I to be completed by the Parent / Guardian.

Part -II to be completed by the Family Physician or General Practitioner or Medical Specialist.

In case any medical problem related to a specialized medical field is detected / documented, you are requested to consult the concerned specialist and enter the details separately.

P A R T – I

Name.....Age.....Defense Personal / Civil
House.....BD/GD/PD-G/B. Blood Group.....Comp. No. .....
Any Known Allergies..... .....

1. Known case of /diagnosed as - {if required kindly tick mark or enter any other Diagnosis in No .viii}
(i) Asthma (ii) Bronchitis (iii) Tonsillitis (iv) Sinusitis (v) Urticaria (vi) Anemia (vii) Epilepsy (viii) Syncope,(ix) Migraine (X) Kidney stones (xi) Anemia (xii) Chr. Orthopedic conditions,(xiii) History of any surgery (xiv) Skin related conditions (xv) Thyroid disorder (xvi) Any other...

X2. A through dental check - up / treatment must be completed during the vacations. However, for any acute dental problem, students are referred to a local Dentist at Dharampur/Solan

3. Only one Orthodontic visit per term is permitted for children who have got their orthodontic treatment from elsewhere. This information about Orthodontic visit must be given in the beginning of each term, duly signed by the Orthodontist.
Orthodontic follow-up required: YES / NO
Name and contact number of Orthodontist

4. In case your child uses glasses / contact lenses it is imperative that she / he brings 3 pair of glasses to School along with the prescription. Two of these are to be duly deposited with the Matron.

5. Has your child suffered from any of the following during the vacation?
Mumps - Yes / No, Measles - Yes / No, German measles -Yes / No, Chicken Pox – Yes / No

6. During the vacations did your child:
* Suffer from any illness?
.....
.
* Undergo any Surgery?
.....
* Sustain any injury / fracture?
.....
* . In case your ward is due for any vaccination, **kindly get it done during the vacation, as it is mandatory to follow the School Vaccination Program, and provide details along with prescription and batch number. The School will administer the vaccinations at School in case these are not taken at home. Non Vaccinated students pose a health risk to others, hence parents may not exempt their wards from the School Vaccination Program**

Please mention any vaccination given during vacation like Covid 19 or any (As applicable)

a) Name of Vaccination …….. date of first dose ……. Date of second dose ……..
b) Name of Vaccination …….. date of first dose ……. Date of second dose ……..
c) Name of Vaccination …….. date of first dose ……. Date of second dose ……..
d) Name of Vaccination …….. date of first dose ……. Date of second dose ……..
e) Name of Vaccination …….. date of first dose ……. Date of second dose ……..

Since the Flu vaccine for the coming year is usually out in the market during Sept /Oct of each year, we will be vaccinating all children in the School. Your consent for the same is required ……..

7. Fitness

The child is fit for extracurricular activities mentioned below [tick mark the activity for which the child is not fit, to be supported by the concerned specialist's prescription in part-II]

PT / Games / Swimming / Hikes / Camps / Treks/ Athletics / Long Distance Runs / Boxing / Gymnastics/ Any others.

8. Consent

I hereby consent to any form of treatment or surgery for my child, which is deemed necessary by the RMO, consulting surgeon / consulting physician/ dental specialist. I authorize the School RMO to sign the consent on my behalf in case of any emergency / investigation / preventive dentistry/routine vaccination including Influenza. The entire expenses will be borne by me. This remains valid throughout the stay of my child in the school.

Signature of Parent / legal Guardian *Date:*

Name .....Full Address……
Email……
Telephone / Mobile No of the Parent / Guardian
…….....

P A R T - I I

TO be filled by the Family Physician or General Practitioner or Medical Specialist

General Examination:

Pathological Examination:

Hb :.....TLC .....DLC :.....ESR :.....

Blood Sugar [R]:.....,:.....

Vitamin D level……

Urine RE:……...

Stool RE…….

Ophthalmologist:
Date of last Eye Test :

	Distant Vision		Near Vision	
	Left	Right	Left	Right
With Glasses				
Without Glasses				

P A R T - III

REMARKS OF SCHOOL MEDICAL OFFICER:

Medical Category:

Signature of RMO:
Date:

Signature of Parent/ Guardian
Date: