INDIAN INSTITUTE OF TECHNOLOGY INDORE

MEDICAL FITNESS FORM

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TO BE SUBMITTED TO HEALTH CENTRE DURING ENROLLMENT AT IIT INDORE

MEDICALFITNESS CERTIFICATE (To be issued by a Registered Medical Practitioner)

PERSONAL HISTORY

PHOTO

1. Name ……..…

2. Parent/ Guardian's Name……...

3. Age ……..……Years ……..……. Months

4. Sex…….

5. Identification Mark on the Body, if any …….. (This can be a mole, scar or birthmark)

*6. Course of Study and Roll No. ……..

*7. Insurance No ……

* **To be filled at the time of enrollment**

CERTIFICATE

(The following are to be filled by a Registered Medical Practitioner conducting the medical examination)

1**. Height** ……..cm

2**. Weight** ……. Kg

3**. Significant History and Examination findings:**

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 caseUnder treatment since….. months Completed treatment in ……. Treatment details if any……Has past history of tuberculosis

f)I have examined the person thoroughly and there is no evidence of tuberculosis .

g) Major illness/ surgery, if any …….…… (Specify nature of illness/ surgery)

h).Were you diagnosed with Covid 19? If yes, When?

i) Any other significant history …….

4**. Blood Group** ……

5. Chest

a) Inspiration ……cm

b) Expiration …….cm

6**. Hearing**……....

7**. Vision with or without glasses**

a) Right Eye……. b) Left Eye……

c) Colour Blindness:Yes ☐ No ☐ d) Any other problem ….....

8**. Respiratory system** ……

9. **Nervous system**/Any psychological disorder-……

10**. Cardiovascular System**……

a) Sounds…….b) Murmur ……

11. **Abdomen**

a) Liver…….. b) Spleen ……..

12. a) Hernia ……. b) Hydrocele ……

13. Any other illness

Certified that…

I have examined……... Son/daughter of ……..……thoroughly and have found that he/she is having……./ he/sheis in sound health to pursue his/her studies at IIT Indore.

Signature of the Medical Officer **Date:**

Name/Registration No. Official Seal

Signature of the Candidate

Date...…….

Full Name.…….....

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Health Centre

Date: _____

All students * should receive following vaccinations prior to admission.

A. Vaccination Certificate:

Name of Vaccine	Date of Vaccine	Doctor's Signature
Typhoid		
Hepatitis A		
MMR (one dose after 15 years of age is essential)		
Chickenpox(If there is no history of chickenpox in past)		
Covid 19		

B. Vaccination Exemption Certificate:

Mr./Ms _____is suffering from _____
and is on_____treatment. Hence, vaccination is contraindicated in him/her.

Registered Medical Practitioner

* Only those students in whom vaccination is medically contraindicated will be exempted from these vaccinations on provision of medical certificate by registered medical practitioner.
