Assam Don Bosco University

Tapesia Gardens, Kamarkuchi Village, Sonapur – 782402 / Airport Road - Azara, Guwahati – 781017 (To be filled in by the student/parent)

A.	Pe	rsonal De	<u>tail</u> s								
NA	ME							DATE OF I	BIRTH		
B. <u>Present Health:</u>1. Is the student receiving medical treason?				lical treatn	nent at prese	nt?		Yes		No 🗌	
	Does he/she take regular medications or in particular circumstances? Yes No If yes, please give details below:										
C		CO	NDITION I		IEDICATION		DOSAGE		WHEN TAKEN		
 Does he/she have any known alle If yes, please complete the follow 			_	=			Yes		No		
			ALLERGEN		RE	ACTION			TI	REATMENT	
 A. <u>Medical History</u> Please indicate (by ticking) whether he/she has suffered or has any of the following health problems. Please add any additional information that you feel is relevant. 											
_	Anaemia		Diabetes		High blood pressure			Meningitis		Thyroid disorder	
	Appendicitis		Hearing problem		Hysteria		Orthopedic problem			Tonsillitis	
-	hma		Frequent nosebleeds					Recurrent headache Sleep walking		Tuberculosis	
	Chicken pox Epilepsy		Hemorrhoids Hernia					th difficulti	Δς.		
2. Physical Disability If he /she has a physical disability, would he/she require special assistance in the college? Please give details:											
PARENT'S CONSENT											
I hereby grant permission to administer First Aid and in the event of an emergency, if								Yes / No			
the	the parents/guardians cannot be reached, permission to take my ward to a hospital if							(please circle one)			
deemed necessary.											
I ce	I certify that all information given on this form is complete and correct										
Sig	Signature of Parent/Guardian:						Date	e:			

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(To be certified by a Licensed Physician/Medical Practitioner)												
This is to certify that I have conducted a thorough physical/mental examination of												
and find that he /she is in a fit state of physical and mental health to be enrolled at the College. He/she does not suffer from any infectious disease(s).												
Height (Cms)		Weight (Kgs)										
Blood Group & RH:												
Date:	Signature	& Official Stamp										
Name of the Licensed Physician/Medical Practitioner												
regu. NO		Contact No										