Indian Institute of Technology – Mandi, H.P., India

MEDICAL FITNESS FORM

(To be completed in your country and submitted during enrolment in IIT Mandi)

PHOTO

1. Full Name……..

*2. Registration No……

*3. Roll No……..

*4. Course of Study……( )YR

4.a. Duration of Study……

*5. Hostel …….. Room No……..

*6. Mobile No…… E-mail Id……

*7. Insurance …… TTK ID No……

8. Date of Birth	Sex		Marital Status		Joined on	Valid Upto
	M	F	S	M		
Permanent Address and Phone No. of Parents					Permanent Address and Phone No. of Local Guardian	

* No.2 to 7 to be filled later. * To be filled during enrollment.

Candidate's Statement / Declaration

This information is collected for the benefit of the students during the stay in the campus.

1. **Personal history** :
   a. Veg / Non-Veg
   b. abuse of substances (if any)

2. **Past medical / surgical records** :		No	Yes
2.1	Allergies / Bronchial asthma	☐	☐
2.2	Abdomen/including urinary tract & G.I. tract	☐	☐
2.3	Locomotor system (spinal/vertebral column/joints)	☐	☐
2.4	Diabetes	☐	☐
2.5	Sexually-transmitted/venereal diseases / Skin	☐	☐
2.6	Hepatitis	☐	☐
2.7	Cardiovascular system	☐	☐
2.8	Neurological disorders/ psychological disorders	☐	☐
2.9	Rheumatism	☐	☐

	2.10	Thyroid disease	☐	☐
3.	**Family history of any major illness**	:	No	Yes
	3.1	Tuberculosis	☐	☐
	3.2	Leprosy	☐	☐
	3.3	Diabetes	☐	☐
	3.4	Hypertension	☐	☐
	3.5	Ischemic heart diseases	☐	☐
	3.6	Psychiatric illness	☐	☐
	2.1	cancer		

4. **Identification Marks** : a.

b.

5. **Blood group** :

I hereby declare that all the above answers are to the best of my knowledge true and correct. I fully understand that I will be held responsible for the accuracy of the above statement.

Candidate's Signature :

Signature of the Parent / Guardian :

Date :

Place :

HEALTH CERTIFICATE

(TO BE COMPLETED BY A DOCTOR OF MEDICINE - *PHYSICIAN, MD)*

I, undersigned, Dr…… …… after the examination (with necessary investigations)of …… born on ……..

certify :

- Weight ……kg. height……cm. blood pressure mm / Hg.
- Girth of Chest: (a) at rest…… (b) after deep inspiration……
- Cardiovascular System : Heart……..
- Neurological System :
- Psychological disturbance : Yes / No If yes specify……..
- Respiratory System :
- Past medical or surgical record :
- Identified allergies :
- Current treatment / medication :
- **Current vaccination status** : (At least one adult booster dose of all these vaccinations are recommended.)

VACCINATION AGAINST DISEASES	1° injection		Last booster	
	Date	Yes / No	Date	Yes / No
Measles, Mumps, Rubella				
Hepatitis B				
Hepatitis A				
Meningitis				
Typhoid				
Chicken pox				

INVESTIGATIONS -

1.	Electrocardiogram	Date.....	Result.....
2.	Chest X-ray (optional) (if ESR is increased)	Date.....	Result.....
3.	Sonography (abdomen)	Date.....	Result.....
4.	Urine	Date.....	Result.....
5.	**Blood Tests**		
	a. Blood Sugar (F/PP)	Date.....	Result.....
	b. Creatinine	Date.....	Result.....
	c. ESR /HB	Date.....	Result.....
	d. Total Choloestrol	Date.....	Result.....
	e. HBS Ag	Date.....	Result.....
	f. HIV - I & II	Date.....	Result.....

Conclusion by Doctor:

Remarks/ special recommendation if any for this person's health care:

Date:

Place;

Signature and Stamp of Doctor with name of the Hospital attached.

II. EXAMINATION OF EYES BY OPHTHALMOLOGIST

	Acuity of Vision	Far Vision		Near Vision		Colour Vision
		Naked eye	With glasses	Naked eye	With glasses	
R.E.						
L.E.						

*Latest Optometrist's Recommendations if any to be attached in original.)

I do hereby certify that I have examined (Full Name)…… candidate who will join Indian Institute of Technology Mandi, H.P., India as ……. ……the year …….. and the above information given to the best of my knowledge are correct and true.

SIGNATURE AND SEAL OF THE OPHTHALMOLOGIST

Date: ……..

Place: ……