MEDICAL FITNESS CERTIFICATE

(To be filled and signed by a Registered Medical Practitioner with stamp and registration number)

PART A – STUDENT DETAILS

- Name of the Student: _____
- Father's Name: _____ Mobile: _____
- Mother's Name: _____ Mobile: _____
- Gender: _____ Date of Birth: _____ Age: _____
- Program Enrolled In: _____
- Blood Group: _____ RH Factor: _____
- Address: _____

  _____

PART B – MEDICAL HISTORY ***(To be filled by the examining physician based on student's disclosure)***

Please indicate if the student has any history of the following (✔ Yes / ✘ No):

Condition	Yes / No	If Yes, Specify Details & Medication (if any)
Asthma or other respiratory issues		
Diabetes		
Epilepsy or Seizures		
Kidney Disease		
Cardiac issues / Hypertension		
Allergies (food, drugs, dust, etc.)		
Psychiatric or mental health issues		
Physical disability or chronic pain		
Hospitalization in the last 12 months		
History of COVID-19		Date: _____ Recovered: Yes / No

PART C – VACCINATION STATUS

Please mention the vaccination status of the student:

Vaccine	Date of Last Dose	Completed? (Yes/No)
COVID-19 (1st & 2nd dose/booster)		
Hepatitis B		
Typhoid		
Tetanus (TT)		
MMR (Measles, Mumps, Rubella)		
Others (if any)		

PART D – CLINICAL EXAMINATION *(To be filled by the physician)*

Parameter	Value / Observation
Height	_____ cm
Weight	_____ kg
Pulse Rate	_____ /min
Blood Pressure	_____ mmHg
Vision (L / R)	_____ / _____
Hearing	Satisfactory / Unsatisfactory
Respiratory System	Satisfactory / Unsatisfactory
Cardiovascular System	Satisfactory / Unsatisfactory
Nervous System	Satisfactory / Unsatisfactory
Musculoskeletal System	Satisfactory / Unsatisfactory

Remarks, if any: _____

_____

PART E – MEDICAL FITNESS DECLARATION

I hereby certify that I have examined the above-named student and based on the findings and the medical history provided:

- The student is **physically and mentally fit** to reside in the hostel and pursue academic activities.
- The student is **free from any contagious or infectious diseases**.
- The student **does not suffer from any serious condition** that may interfere with residential or academic life.
- The student **does not have any chronic medical condition** which requires regular and sustained medical treatment.

Doctor's Name: _____ Registration No.: _____

Signature: _____ Date: _____ Place: _____

Seal / Stamp of Medical Practitioner
