SCMS SCHOOL OF TECHNOLOGY AND MANAGEMENT

PRATHAP NAGAR, MUTTOM, ALUVA-683 106

Medical Fitness Certificate

A. Name :

Age: **(**in completed yrs) **Gender:** Male//Female **(tick)** **Blood Group:**

Height: ……. cms **Weight:** ……. Kgs

B. Medical History:

Any past/current serious ailment requiring medical care ? Yes / No

If "Yes "(please indicate period, type & nature of ailment, treatment undertaken and if **allergic** please specify) (Please use additional sheets if required)

If currently under treatment

Name of the hospital & Name of the attending Medical Practitioner

Details of medication prescribed and dosage

Is there a need for follow up by a physician/specialist at Cochin at regular intervals? (YES/NO)
If 'YES' please provide nature and regularity of check ups.

C. Declaration by the candidate and Parent

I declare that the details given above are true to the best of my knowledge.

Signature of the Student **Name and signature of the parent** **Date:**

D. Certification by Medical practitioner

I have examined Mr./ Ms. …… and certify that his/her mental and physical health condition is free from any mental or physical infirmity which may interfere with his/her studies including the active outdoor duties required of a professional course.

Name and Signature

Registration Number and Seal **Date:**