WELHAM BOYS' SCHOOL
HOSPITAL

Name:

WBS No./House:

	Starting of the Term	End of the Term
Height		
Weight		

Kindly get following vaccination completed during the holidays.

S No.	Name of the vaccine	Batch No.	Date	Date
01				
02				
03				
04				

Kindly addresses the following wherever applicable:

- Encourage the child in optimizing his BMI (Body Mass Index).
- Dental examination by a qualified dentist.
- Corns and warts to be treated before he returns.
- Follow up for flatfoot/Gait abnormality during holidays.
- Encourage good personal hygiene practices.
- School dose not encourage Orthodontic / Dental leave under all conditions. The treatment initiated at home will be followed in consultation with the treating Dentist with utmost care and precision.
- We also request you to kindly provide all the medical documents without fail for any medical ailment treated during the holidays before the child rejoins the hostel.
- Providing Over the counter (OTC) medicines to the child by the parent or guardian is highly discouraged by the school hospital, as this may interfere with the right diagnosis of the ailment during his stay in school.
- Any additional nutritional supplement possessed by the child at the time of reporting is not encouraged. Where ever required it will be provided through the school hospital.
- Kindly do not with hold any significant medical history from the school health care system.

Medical Certificate

(To be certified by a qualified doctor)

I hereby certify that I have thoroughly examined Master/ Ms _______________________________

SO/DO _____________________________________ and found him/her in good health and fit for normal residential school life and work. I have particularly given him/her skin examination and certify that he/she is not suffering from ringworm /scabies/Mumps/Chickenpox or any other transmittable disease. To the best of my knowledge belief he/she has not, during the last 30 days suffered from or has been exposed to any infection or contagious disease.

Further remarks if any:____

____

Date: _____________ Seal and Signature of the doctor

Eye Examination:

Right Eye				Left Eye			
Spherical	**Cylindrical**	**Axis**	**Vision**	**Spherical**	**Cylindrical**	**Axis**	**Vision**

For Near add + ___________________

Remarks:
____

Date: __________________ Seal and Signature of the doctor

Signature of the Parent/Guardian

Date:________________