MEDICAL FITNESS FORM

(Must Submit Original Copy at the time of Admission)

NAME : ____

AGE : ___________ SEX: Male/Female

Personal History : Addiction to Tobacco / Cigarette/ Alcohol/ Other

Allergy/ To Drug/Food/Others

Family History : H/O of HTN / DM/ Br. Asthma/I.H.D

General Examination:-

Weight :

Height :

Pulse :

B. P. :

EYE - Acuity of Vision

Colour Vision

EAR -

Blood Group-

____

(Verified by Medical Practitioner with Regd. No)

Please obtain the Medical certificate only from the following authorized Doctors:

1. Dr. S.K. Mitra Mobile no - 7250736916
Time : - 12 PM - 3 PM Place : St Xavier's College Clinic
2. Dr. N.K. Bhagat (Mobile No - 9431189435)
Time : 7 AM - 9 AM / 3.30 PM - 7PM
Place : Near Pantaloons, Lalpur