Prin. L.N.Welingkar Institute of Management Development and Research, Mumbai-400019

Master of Management Studies

Medical History form

(A) To be filled by the Candidate

Photo

Full Name: _____

Surname First name Middle name

Gender: Male / Female Blood Group: _____

Tel No _____ (Home) _____ (Mobile)

Local guardian: _____Relationship: _____

Local guardian's Contact: _____ (Home) _____ (Mobile)

Family Physician Name and contact No:_____

_____ (Home) _____ (Mobile)

1. Are you currently under any medical treatment ? □ No □ Yes
2. Are you currently under treatment or have been treated in the last five years by a psychiatrist, clinical psychologist, or other mental health professional? □ No □ Yes

If "Yes"to Question no 5 and / or 6, please provide details (diagnosis, treatment, date and duration, etc)

_____

3. Are you currently taking ANY MEDICINE on a daily basis? □ No □ Yes

If, YES, please list the medication and the conditions you are taking it for:

Medication	Condition

The information provided here will be strictly confidential and is to be used should any untoward incident occur.

I understand that I am responsible for my own physical and mental health, and for informing staff incase of any need for treatment.

I hereby affirm that all information supplied is complete and accurate to the best of my knowledge.

I hereby grant permission to WeSchool to make necessary referrals; to release medical information necessary for appropriate care and treatment, and to authorize hospitalization when recommended in the event of illness or accident.

I understand that WeSchool cannot be held responsible for any medical incident occurring during my student days & for any financial obligations thereof.

Name of the student :___ _____ _____ Date _____

Signature of student : ___ _____ _____

Contact No: _____

Name of parent or guardian: _____ _____ Date _____

Signature of parent or guardian: : ___ _____ _____

Contact No:_____

The information provided here will be strictly confidential and is to be used should any untoward incident occur.

(B) To be Filled by the Physician

1. **History of Allergy: Please tick and explain the reaction**

None	Medication	Food	Environmental

2. Personal Medical History/Disorder/Problem – Please tick with brief comment where applicable

S.No	Condition	□ No	□ Yes	Comment (medications if any)
1	H/o any medical illness lasting for more than six months			
2	H/o any medical illness requiring overnight hospitalization			
3	H/o previous surgery			
4	H/o diabetes			
5	H/o High or Low BP			
6	H/o Jaundice			
7	H/o Kidney disease			
8	H/o Thyroid			
9	H/o Asthma			
10	H/o Convulsions (fits) / Seizures requiring medical supervision			
11	H/o Ear Nose Throat problems			
12	H/o Tuberculosis			
13	H/o Skin Rash / Eczema / Dermatitis / other Skin Disease / Allergy?			

Name & Signature of Certifying doctor: _____

Doctor's Contact details: _____ (Home) _____ (Mobile)

Doctor Seal & Medical Council Registration Number

Place: _____ Date: _____

The information provided here will be strictly confidential and is to be used should any untoward incident occur.