**SCHOOL HEALTH CARD**

Name ................................................... Class ..................

Age ................................... Sex ........................................

Address .............................................................................

..........................................................................................

Mobile ............................... Residence .............................

Blood Group .....................................................................

The Major Parameters On Which The Annual Medical Checkup Done Are :

Dental ..............................................................................

Eyes..................................................................................

General Examination .........................................................

Allergy (if any) ..................................................................

Date of Examination ..........................................................

Past Family History ...........................................................

GENERAL :

Heigh ............................. Weight .......................................

Nails ................................................................................

Hair ..................................................................................

Skin ..................................................................................

Anaemia (Mild, Moderate, Severe or Absent) .......................

Ear ...................................................................................

Nose .................................................................................

Throat ..............................................................................

Neck .................................................................................

Dental Examination ...........................................................

1. Extra Oral ......................................................................

2. Intra Oral

a) Tooth Cavity ................... b) Plaque .......................

c) Gum Inflammation ............... d) Stains ........................

e) Tarter ............................. f) Bad Breath ..................

g) ....................................... h) Soft Tissue ................

Medical Officer's Name And Signature ..............................

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Follow Up ..........................................................................

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Parents Signature

Father .......................... Mother .............................