

**M.I.C.**

Form No. \_\_\_\_\_ Issue Date \_\_\_\_\_  
Child's Name \_\_\_\_\_ Class \_\_\_\_\_ Yr. \_\_\_\_\_ to \_\_\_\_\_  
A.O. No. \_\_\_\_\_ Dt. \_\_\_\_\_ Admission No. \_\_\_\_\_ Admission Dt. \_\_\_\_\_  
Father's Name \_\_\_\_\_ Tel. \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_ Official's Sig. \_\_\_\_\_

**Sanskar International School™ Dehradun.**  
Medical Information Chart (M.I.C.)

No. \_\_\_\_\_ Date: \_\_\_\_\_

CHILD'S NAME \_\_\_\_\_

DATE OF BIRTH: In figures \_\_\_\_\_ In Words \_\_\_\_\_

FATHER'S: NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONES:1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

E-MAIL: \_\_\_\_\_ FAX \_\_\_\_\_

Sig. \_\_\_\_\_

BLOOD GROUP \_\_\_\_\_

HISTORY OF PAST DISEASE : \_\_\_\_\_

B.P.(High/Low) \_\_\_\_\_ DIABETES:(Yes/No) \_\_\_\_\_ EPILEPSY:(Yes/No) \_\_\_\_\_ ASTHMA(Yes/No) \_\_\_\_\_

HISTORY OF VACCINATIONS: \_\_\_\_\_

OPERATIVE PROCEDURE IF ANY: \_\_\_\_\_

HISTORY OF DRUG ALLERGY OR ANY OTHER ALLERGY: \_\_\_\_\_

DOCTOR'S NAME: \_\_\_\_\_ Sig. \_\_\_\_\_

Medical Council Reg. No \_\_\_\_\_ Date \_\_\_\_\_

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**FOR OFFICE USE ONLY**

Remarks \_\_\_\_\_

A.O. No. \_\_\_\_\_ Dt. \_\_\_\_\_

ADMISSION NO. \_\_\_\_\_ ADMISSION DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

C.E.O., Sanskar International School™ Dehradun.