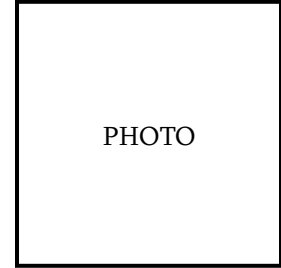


Indian Institute of Technology - Madras, Chennai
 Medical Fitness form(to be completed in your country and
 submitted during enrollment in IIT Madras)

1. Full Name.....
- *2. Registration No.....
- *3. Roll No.....
- *4. Course of Study.....()YR
 4.a. Duration of Study.....
- *5. Hostel Room No.....
- *6. Mobile No..... E-mail Id.....
- *7. Insurance TTK ID No.....



8. Date of Birth	Sex		Marital Status		Joined on	Valid Upto
	M	F	S	M		
Permanent Address and Phone No. of Parents					Permanent Address and Phone No. of Local Guardian	

* No.2 to 7 to be filled later. * To be filled during enrollment.

Candidate's Statement / Declaration

This information is collected for the benefit of the students during the stay in the campus.

1. **Personal history** : a. Veg / Non-Veg
 b. abuse of substances (if any)
2. **Past medical / surgical records** :
- | | No | Yes |
|---|--------------------------|--------------------------|
| 2.1 Allergies / Bronchial asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| 2.2 Abdomen/including urinary tract & G.I. tract | <input type="checkbox"/> | <input type="checkbox"/> |
| 2.3 Locomotor system (spinal/vertebral column/joints) | <input type="checkbox"/> | <input type="checkbox"/> |
| 2.4 Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| 2.5 Sexually-transmitted/venereal diseases / Skin | <input type="checkbox"/> | <input type="checkbox"/> |
| 2.6 Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> |
| 2.7 Cardiovascular system | <input type="checkbox"/> | <input type="checkbox"/> |
| 2.8 Neurological disorders/ psychological disorders | <input type="checkbox"/> | <input type="checkbox"/> |
| 2.9 Rheumatism | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | | | | |
|----|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 3. | 2.10 Thyroid disease | No | <input type="checkbox"/> | Yes | <input type="checkbox"/> |
| | Family history of any major illness : | | | | |
| | 3.1 Tuberculosis | <input type="checkbox"/> | | <input type="checkbox"/> | |
| | 3.2 Leprosy | <input type="checkbox"/> | | <input type="checkbox"/> | |
| | 3.3 Diabetes | <input type="checkbox"/> | | <input type="checkbox"/> | |
| | 3.4 Hypertension | <input type="checkbox"/> | | <input type="checkbox"/> | |
| | 3.5 Ischemic heart diseases | <input type="checkbox"/> | | <input type="checkbox"/> | |
| | 3.6 Psychiatric illness | <input type="checkbox"/> | | <input type="checkbox"/> | |
| | 2.1 cancer | | | | |

4. **Identification Marks** : a.
- b.

5. **Blood group** :

I hereby declare that all the above answers are to the best of my knowledge true and correct.
I fully understand that I will be held responsible for the accuracy of the above statement.

Candidate's Signature :

Signature of the Parent / Guardian :

Date :

Place :

HEALTH CERTIFICATE

(TO BE COMPLETED BY A DOCTOR OF MEDICINE - *PHYSICIAN, MD*)

I, undersigned, **Dr**..... after the examination
(with necessary investigations)of born on

certify :

- Weightkg. height.....cm. blood pressure mm / Hg.
- Girth of Chest: (a) at rest..... (b) after deep inspiration.....
- Cardiovascular System : Heart.....
- Neurological System :
- Psychological disturbance : Yes / No If yes specify.....
- Respiratory System :
- Past medical or surgical record :
- Identified allergies :
- Current treatment / medication :
- **Current vaccination status :** (At least one adult booster dose of all these vaccinations are recommended.)

<i>VACCINATION AGAINST DISEASES</i>	1° injection		Last booster	
	Date	Yes / No	Date	Yes / No
Measles, Mumps, Rubella				
Hepatitis B				
Hepatitis A				
Meningitis				
Typhoid				
Chicken pox				

INVESTIGATIONS -

- | | | | |
|----|---|-----------|-------------|
| 1. | Electrocardiogram | Date..... | Result..... |
| 2. | Chest X-ray (optional)
(if ESR is increased) | Date..... | Result..... |
| 3. | Sonography (abdomen) | Date..... | Result..... |
| 4. | Urine | Date..... | Result..... |
| 5. | Blood Tests | | |
| | a. Blood Sugar (F/PP) | Date..... | Result..... |
| | b. Creatinine | Date..... | Result..... |
| | c. ESR /HB | Date..... | Result..... |
| | d. Total Choloestrol | Date..... | Result..... |
| | e. HBS Ag | Date..... | Result..... |
| | f. HIV - I & II | Date..... | Result..... |

Conclusion by Doctor:

Remarks/ special recommendation if any for this person's health care:

Date:

Place;

Signature and Stamp
of
Doctor with name of the
Hospital attached.

II. EXAMINATION OF EYES BY OPHTHALMOLOGIST

	Acuity of Vision	Far Vision		Near Vision		Colour Vision
		Naked eye	With glasses	Naked eye	With glasses	
R.E.						
L.E.						

***Latest Optometrist's Recommendations if any to be attached in original.)**

I do hereby certify that I have examined (Full Name)
 candidate who will join the Indian Institute of Technology Madras
 as..... the year.....and the above
 information given to the best of my knowledge are correct and true.

SIGNATURE AND SEAL OF THE OPHTHALMOLOGIST

Date :

Place :

III. EXAMINATION BY ENT SURGEON

	Inspection / hearing	*Audiometry
Right Ear		
Left Ear		

*** Latest Audiometry report to be attached.**

I do hereby certify that I have examined (Full Name)
 candidate who will join the Indian Institute of Technology Madras
 as.....the year.....andd the above
 information given to the best of my knowledge are correct and true.

SIGNATURE AND SEAL OF THE ENT SURGEON

Date:

Place: