RV COLLEGE OF ENGINEERING
RVCE BOYS HOSTEL
MEDICAL FITNESS FORM
(TO BE COMPLETED BY THE CANDIDATE ON ADMISSION TO RVCE HOSTEL)

1. Full Name (BLOCK LETTERS)……………………………………

2. Course of Study: BE/ MTech/MCA

3. Duration of Study………………

4. Hostel ................................. Room No..................

5. Mobile No..............................

6. E-mail Id.................................

7. Date of Birth.........................

8. Sex.................................

9. Permanent Address and Phone No. of Parents

10. Permanent Address and Phone No.of Local Guardian
Candidate’s Statement / Declaration
This information is collected for the benefit of the students during the stay in the campus.

1. Personal history:
   abuse of substances (alcohol/ tobacco/drug/any other substances)

2. Past medical / surgical records: No/ Yes
   2.1 Allergies / Bronchial asthma
   2.2 Abdomen/including urinary tract & G.I. tract
   2.3 Locomotor system (spinal/vertebral column/joints)
   2.4 Diabetes
   2.5 Skin
   2.6 Hepatitis
   2.7 Cardiovascular system
   2.8 Neurological disorders/ psychological disorders

3. Family history of any major illness (To be specified):

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.

Date:
Place:

Candidate’s Signature:

Signature of the Parent / Guardian:
HEALTH CERTIFICATE
(TO BE COMPLETED BY A PHYSICIAN)

I, undersigned, Dr……………………………………… after the examination (with necessary investigations) of …………………………… born on ……………………………
certify:
- Weight:……….kg. 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.)

<table>
<thead>
<tr>
<th>VACCINATION AGAINST DISEASES</th>
<th>1° injection</th>
<th>Last booster</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measles, Mumps, Rubella</td>
<td>Date Yes/No</td>
<td>Date Yes/No</td>
</tr>
<tr>
<td>Hepatitis B</td>
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<tr>
<td>Hepatitis A</td>
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<td>Meningitis</td>
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<tr>
<td>Typhoid</td>
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<tr>
<td>Chicken pox</td>
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</tbody>
</table>

**INVESTIGATIONS** -
1. Complete blood count
2. ESR
3. Fasting blood sugar
4. Chest X RayPA view
5. Urine routine

**Conclusion by Doctor:**

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

Date:
Place:

Medical officer  Signature