**MEDICAL FITNESS CERTIFICATE**

Photo

Name: ………………………………………..

Father’s Name: …………………………………………

Gender: …………………………………………

Age: …………………………………………

1. Weight: ……………… (Kgs)   Height ………………… (cm)   BP: ………………………........
2. Lungs: …………………………………………… Blood Group: ………………………......
3. Heart: ……………………………………
4. Vision: Left Eye ……………. Right Eye ………… Details of Glasses (if Worn).........................
5. Hearing:…………………………………………………………………………………………….
6. Any impediment in speech: …………………………………………………………………..........
7. Any Disability: ……………………………………………………………………………………..
8. Any Neurological / Psychiatric Disease, (if, yes, please give details) ……………………………..
9. Suffering from Hepatitis B / Hepatitis C / HIV (AIDS) …………………………………………...
10. Any significant disease diagnosed in the past: …………………………………………………….
11. Vaccinated (Yes/No/Partially: ……………………………………………………………………..
12. Taking any medicine on a regular basis (if yes, please give details): ……………………………..
13. Allergies if any: ……………………………………………………………………………………
14. Any communicable/contagious disease: ………………………………………………………......
15. Mark of identification: ………………………………………………………

I certify that I have examined Mr / Ms …………………………… Son/Daughter of ……………………….. and could not notice that he/she has any physical or mental disease.

Place:

Date:

Medical officer's signature

 & Seal