

Prin. L.N.Welingkar Institute of Management Development and Research,
Mumbai-400019

Master of Management Studies

Medical History form

(A) To be filled by the Candidate

Photo

Full Name: _____

Surname

First name

Middle name

Gender: Male / Female Blood Group: _____

Tel No _____ (Home) _____ (Mobile)

Local guardian: _____ Relationship: _____

Local guardian's Contact: _____ (Home) _____ (Mobile)

Family Physician Name and contact No: _____

_____ (Home) _____ (Mobile)

1. Are you currently under any medical treatment ? ☐ No ☐ Yes
2. Are you currently under treatment or have been treated in the last five years by a psychiatrist, clinical psychologist, or other mental health professional? ☐ No ☐ Yes

If "Yes" to Question no 5 and / or 6, please provide details (diagnosis, treatment, date and duration, etc)

3. Are you currently taking ANY MEDICINE on a daily basis? ☐ No ☐ Yes

If, YES, please list the medication and the conditions you are taking it for:

Medication	Condition

The information provided here will be strictly confidential and is to be used should any untoward incident occur.

I understand that I am responsible for my own physical and mental health, and for informing staff in case of any need for treatment.

I hereby affirm that all information supplied is complete and accurate to the best of my knowledge.

I hereby grant permission to WeSchool to make necessary referrals; to release medical information necessary for appropriate care and treatment, and to authorize hospitalization when recommended in the event of illness or accident.

I understand that WeSchool cannot be held responsible for any medical incident occurring during my student days & for any financial obligations thereof.

Name of the student : _____ Date _____

Signature of student : _____

Contact No: _____

Name of parent or guardian: _____ Date _____

Signature of parent or guardian: : _____

Contact No: _____

The information provided here will be strictly confidential and is to be used should any untoward incident occur.

(B) To be Filled by the Physician

1. History of Allergy: Please tick and explain the reaction

None	Medication	Food	Environmental

2. Personal Medical History/Disorder/Problem – Please tick with brief comment where applicable

S.No	Condition	☐ No	☐ Yes	Comment (medications if any)
1	H/o any medical illness lasting for more than six months			
2	H/o any medical illness requiring overnight hospitalization			
3	H/o previous surgery			
4	H/o diabetes			
5	H/o High or Low BP			
6	H/o Jaundice			
7	H/o Kidney disease			
8	H/o Thyroid			
9	H/o Asthma			
10	H/o Convulsions (fits) / Seizures requiring medical supervision			
11	H/o Ear Nose Throat problems			
12	H/o Tuberculosis			
13	H/o Skin Rash / Eczema / Dermatitis / other Skin Disease / Allergy?			

Name & Signature of Certifying doctor: _____

Doctor's Contact details: _____ (Home) _____ (Mobile)

Doctor Seal & Medical Council Registration Number

Place: _____

Date: _____

The information provided here will be strictly confidential and is to be used should any untoward incident occur.