Medical History for New Students

Name: _____

Age:_____, Height (cm):_____, Weight (Kg): _____

Blood Group: _____

Disability If Any: _____

History of Allergy/Drug Reaction (Food/Medicine/any other substances):

_____

Allergy to: _____

Special Medical History: Diabetes/Hypertension/Asthma/Tuberculosis/Seizure/Autoimmune Disorder/ Mental Health Concern/ Hematological Concern.

If any mention the details: _____

Family History: Diabetes/Hypertension/Asthma/Tuberculosis/Seizure/Autoimmune Disorders/ Hematological Concern.

Vaccination Status (according to National Immunization Schedule of India): _____

**Attach the copy of the Vaccination record card to this document duly attested by the CMO/Pediatrician.

This is a self declaration to be duly attested by a Registered Medical Practitioner.

भारतीय विज्ञान शिक्षा और अनुसंधान संस्थान कोलकाता
INDIAN INSTITUTE OF SCIENCE EDUCATION AND RESEARCH KOLKATA
Mohanpur – 741246, Dist. Nadia, West Bengal

IISER KOLKATA

Admission to BS-MS Dual Degree/Master of Science/MS in Space Physics/Integrated PhD/ PhD Programme

DECLARATION FORM FOR MENTAL HEALTH ISSUES OF THE STUDENT
(to be given by the Students' parents)

Please tick (√) appropriate boxes

Application No.:	Program: BS-MS ☐ Master of Science (MP) ☐ MS in Space Physics (MR) ☐ IPhD ☐ PhD ☐
Admission Channel for BS-MS Program:	KVPY ☐ JEE Advanced ☐ SCB ☐
Category:	GE ☐ OBC-NCL ☐ SC ☐ ST ☐ EWS ☐ KM ☐
Person with Disability (PwD):	Yes ☐ No ☐
Student's Name:	Parent's /Guardian's Name:
Address for Communication:	
Contact No. of Student: Contact No. of Parent/Guardian:	Email ID of Student: Email ID of Parent/Guardian:

1. I hereby declare that my son/ daughter has past history of mental health issues and he/she has undergone psychological/psychiatric treatment. I hereby, submit all medical investigation reports related to his/her medicaltreatment. *Please tick:* ☐

2. I hereby declare that my son/ daughter does have not any past history of mental health issues and he/she has not undergone any psychological/psychiatric treatment. *Please tick* ☐

If 1. is applicable, kindly submit all medical investigation report of the student.
(All information will be kept confidential).

Signature of the Parents/Guardian

Date:
Place: