

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): _____

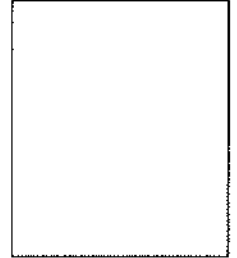
**Attach the copy of the Vaccination record card to this document duly attested by the
CMO/Pediatrician.



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

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 <input type="checkbox"/> Master of Science (MP) <input type="checkbox"/> MS in Space Physics (MR) <input type="checkbox"/> IPhD <input type="checkbox"/> PhD <input type="checkbox"/>
Admission Channel for BS-MS Program:	KVPY <input type="checkbox"/> JEE Advanced <input type="checkbox"/> SCB <input type="checkbox"/>
Category:	GE <input type="checkbox"/> OBC-NCL <input type="checkbox"/> SC <input type="checkbox"/> ST <input type="checkbox"/> EWS <input type="checkbox"/> KM <input type="checkbox"/>
Person with Disability (PwD):	Yes <input type="checkbox"/> No <input type="checkbox"/>
Student's Name:	Parent's /Guardian's Name:
Address for Communication:	
Contact No. of Student:	Email ID of Student:
Contact No. of Parent/Guardian:	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 medical treatment. Please tick: <input type="checkbox"/>	
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: <input type="checkbox"/>	
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: