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   <!DOCTYPE html>
   <html>
3
   <head>
     <title>Course Management Form</title>
   </head>
   <body>
   <style>
8
   body {
         background-color: #f0f8ff; /* sky blue
   background */
         font-family: Arial, sans-serif;
12
        .form-container {
13
         background-color: #ffffff;
14
         width: 400px;
15
16
         padding: 20px;
         margin: 50px auto;
17
18
         border-radius: 10px;
         box-shadow: 0 0 10px rgba(0,0,0,0.2);
19
20
21
       </style>
22
     <h2>Course Management Form</h2>
23
24
     <form>
25
       <label for="courseId">Course ID:</label><br>
       <input type="text" id="courseId"</pre>
26
   name="courseId"><br><br><br></pr>
27
28
       <label for="courseName">Course Name:
   label><br>
       <input type="text" id="courseName"</pre>
29
   name="courseName"><br><br>
30
       <label for="duration">Duration:</label><br>
31
       <input type="text" id="duration"</pre>
32
   name="duration"><br><br>
33
34
       <label for="fees">Fees:</label><br>
       <input type="number" id="fees"</pre>
   name="fees"><br><br>
36
       <input type="submit" value="Submit">
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Course Management Form

Course ID:	-
Course Name:	
Duration:	
Fees:	-
Submit	

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   <!DOCTYPE html>
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   <html>
3
   <head>
     <title>Patient Record Form</title>
   </head>
   <body>
   <style>
   body {
         background-color: #f0f8ff; /* sky blue
   background */
         font-family: Arial, sans-serif;
10
12
13
        .form-container {
         background-color: #ffffff;
14
         width: 400px;
15
16
         padding: 20px;
         margin: 50px auto;
17
18
         border-radius: 10px;
         box-shadow: 0 0 10px rgba(0,0,0,0.2);
19
20
21
       </style>
22
23
     <h2>Patient Record System</h2>
24
25
     <form>
       <label for="patientId">Patient ID:
26
   label><br>
27
       <input type="text" id="patientId"</pre>
   name="patientId"><br><br><
28
29
       <label for="name">Name:</label><br>
       <input type="text" id="name"</pre>
30
   name="name"><br><br>
31
       <label for="age">Age:</label><br>
32
       <input type="number" id="age"</pre>
33
   name="age"><br><br>
34
       <label>Gender:</label><br>
       <input type="radio" id="male" name="gender"</pre>
   value="Male">
       <label for="male">Male</label>
37
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20
       </style>
21
22
     <h2>Patient Record System</h2>
23
24
     <form>
25
       <label for="patientId">Patient ID:
26
   label><br>
       <input type="text" id="patientId"</pre>
27
   name="patientId"><br><br>
28
29
       <label for="name">Name:</label><br>
       <input type="text" id="name"</pre>
30
   name="name"><br><br>
31
       <label for="age">Age:</label><br>
32
       <input type="number" id="age"</pre>
33
   name="age"><br><br>
34
       <label>Gender:</label><br>
35
       <input type="radio" id="male" name="gender"</pre>
36
   value="Male">
       <label for="male">Male</label>
37
       <input type="radio" id="female" name="gender"</pre>
38
   value="Female">
       <label for="female">Female</label>
39
       <input type="radio" id="other" name="gender"</pre>
40
   value="Other">
41
       <label for="other">Other</label><br><br>
42
       <label for="phone">Phone:</label><br>
43
       <input type="text" id="phone"</pre>
44
   name="phone"><br>
45
       <label for="symptoms">Symptoms:</label><br>
46
       <textarea id="symptoms" name="symptoms"
47
   rows="4" cols="30"></textarea><br><br>
       <input type="submit" value="Submit">
49
50
     </form>
   </body>
52
  </html>
53
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Patient Record System

Patient ID:
Name:
Age:
Gender:
O Male O Female O Other
Phone:
Symptoms:
Submit