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| **HEALTH REPORT CARD**  Health Camp Conducted on:  NAME  DIV- | ROLL NO.-|ADMIN NO.-  Father’s Name  Mother’s Name  Address:  Mobile/Phone No.  DOB? Gender  Blood Group |

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| E.N.T EXAMINATION REPORT  (1) EAR  LEFT EAR RIGHT EAR  NO  YES  NO  YES  Deformity Deformity  NO  YES  NO  YES  Wax Wax  UNSEEN  SEEN  UN SEEN  SEEN  Tympanic Membrane Tympanic Membrane  YES  YES  NO  Discharge Discharge  NO  Normal Hearing Normal Hearing  NO  YES  NO  YES  (2) NOSE  LEFT NOSE RIGHT NOSE Nasal Obstruction Nasal Obstruction  NO  YES  NO  YES  Discharge Discharge  NO  YES  NO  YES  (3) THROAT (4) NECK  ENLARGED/ NOT ENLARGED  PRESENT/ABSENT  NO  YES  Throat Pain Neck Nodes Tonsils    VISION EXAMINATION REPORT   1. VISION   RE 6/6 LE 6/6   1. COLOR BLINDNESS Right Eye Color Blindness No /YES Left Eye Color Blindness No/YES 2. SQUINT   Right Eye Squint No/YES Left Eye Squint No/YES |

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| GENERAL EXANIMATION REPORT  Height Weight BMI   1. GENERAL CLEANLINESS   Nails No Abnormality/Abnormality Hair Abnormality/No Abnormality  Skin No Abnormality/Abnormality (2) ANEMIA/ FIGURE  Anemia/Figure No Abnormality/Abnormality  (3) ALLERGY  Allergy No/YES  (4) ABDOMEN  Soft Yes/ No Hard Yes/No  Distended Yes/No Bowel Sound Yes/No  (5) CENTRAL NERVOUS SYSTEM  Conscious Yes/NO Oriented Yes/NO  Playful Yes/NO Active Yes/NO  Alert Yes/NO Speech Normal/Abnormal  (6) PAST HISTORY  Medical YES/No Surgical YES/No    VITALS EXAMINATION REPORT  B.P Pulse  CIRCUMFERENCES  Hip Waist    BMI CHART  Normal 18.5-24.9 Underweight less than 18.5 Overweigh 25-29.9 Obese 30& Above |
| DENTAL EXAMINATION REPORT  (I) Extra-Oral  Extra-Oral No Abnormality/Abnormality  (II) Intra-Oral  (a) Tooth Cavity (Permanent Teeth)  18 17 16 14 13 12 11 21 22 23 24 25 26 27 28  48 47 46 45 44 43 42 41 31 32 33 34 35 36 37 38  (b) Tooth Cavity (Primary Teeth)  55 54 53 52 51 61 62 63 64 65  85 84 83 82 81 71 72 73 74 75  (c) Plaque Present/ Absent (d) Gum Inflammation Present/ Absent  (e) Stains Present/ Absent (f) Tooth Discoloration Present/ Absent  (g) Tarter Present/ Absent (h) Bad Breadth Present/ Absent  (i) Gum Bleeding Present/ Absent (j) Soft Tissue No Abnormality/Abnormality  (k) Fluorosis Present/ Absent (l) Malocclusion Present/ Absent  (m) Root Stump Present/ Absent (n) Missing Teeth Present/ Absent    Dental Examination Remarks    Health Tips: Healthy & Balanced Diet, Proper Hydration & Exercise, Good Hygiene helps maintain Healthy Lifestyle    Medical Officer Name:    Disclaimer: All findings are noted on the day of Medical Check-up |