

PROFORMA II

- | | | | |
|------------------|------------|------------------|-------------------|
| 3. Skin colour : | Anaemia | Cyanosis | Jaundice |
| 4. Eyes vision : | Acuity | Colour blindness | |
| * Conjunctiva : | Congestion | Anaemia | Bitot's spot |
| * Cornea : | Ulcers | Opacity | |
| * Pupils : | Size | Equality | Reaction to light |
| 5. Mouth : | Teeth | Gums | |
| Throat : | | | |
| Tongue : | | | |

- | | | |
|---------------------------------|-----------------------------|---------|
| 6. Ears : | Discharge / Any abnormality | Hearing |
| 7. Congenital defects, if any : | | |

8. Genitals :

 Hydrocele :

 Hernia :

* Systemic Examination :

(Write diagnosis only if abnormality is noted)

I. Respiratory System:

II. Cardiovascular System

III. Abdomen

IV. Central Nervous System:

Referral required :

Referred to :

For

Signature of M.O.	Name	Designation	Station

PROFORMA I

FOR SCHOOL HEALTH PROGRAMME

A. NAME OF THE DIVISION

DATE OF EXAMINATION

Name and of school :

Name of the student :

Standard

Name of Father / Guardian :

Sex : Male / Female

Address :

Date of Birth _____ Height (cm) _____ Weight(kg) _____

Please tick mark as applicable.

B. IMMUNIZATON STATUS

SL.NO	IMMUNIZATON	COMPLETE	INCOMPLETE	NOT GIVEN
1.	BCG			
2.	DPT			
3.	POLIO			
4.	DPT BOOSTER (1 st & 2 nd)			
5.	POLIO BOOSTER (1 st & 2 nd)			
6.	MEASLES			
7.	TETANUS			
8.	ENTERIC FEVER			
9.	CHOLERA			

C. Past history of any significant illness.

D. Physical Examination :

* General Examination :

1. General appearance.

2. State of Nutrition

Under- nourished

Well- nourished

Specific Deficiency, if any:

SCHOOL HEALTH REGISTRER

CLASS :

SECTION :

SL. NO	Date	Name	Sex/Age	Address	Height (cm)	Weight (kg)	Immunization Status	Defect detected	Follow up Act	Teacher's observation	Vision	Remarks
1	2	3	4	5	6	7	8	9	10	11	12	13

