



Crescent Schools

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MEDICAL REPORT FORM

This form must be filled, signed and stamped by a Medical Doctor from a recognized hospital

NAME: _____

AGE: _____ GENDER: _____

ADDRESS: _____

HEIGHT: _____ WEIGHT: _____

GENOTYPE: _____ BLOOD GROUP: _____ P.C.V _____

Any known medical complaint: _____

Any known drug reaction: _____

Any past Admission (Yes/No) why _____

Any past surgical history: _____

Any blood transfusion: _____

Does he/she have any of the following? Please tick where applicable

Asthma
Yes No

Ulcer
Yes No

Eye problem
Yes No

others
Yes No

Doctor's Name

Signature, Date & Stamp
