Sri Sathya Sai Institute of Higher Learning

(Deemed to be University)
Vidyagiri, Prasanthi Nilayam – 515 134, Anantapur District, Andhra Pradesh
--:--

SUBMIT THIS FORM WHILE JOINING THE INSTITUTE

HEALTH RECORD

1. Name: _____ 2. Applicant Id.:_____

3. Height: _____(cms) 4. Weight : ____(kgs) 5. Age: _____ 6. Blood Group: _____

7. Identification Marks :

   7.1 _____

   7.2
   _____

8. Have you suffered from any of the following illnesses? If yes, furnish details regarding duration, medication, and present condition. (Put tick mark where applicable)

   8.1. Skin lesions (Yes☐ / No ☐) ……

   8.2. Tuberculosis (Yes☐ / No ☐) ……

   8.3. Bronchial Asthma (Yes☐ / No ☐) ……

   8.4. Chicken pox/Mumps (Yes☐ / No ☐) ……

   8.5. Epilepsy (Yes☐ / No ☐) ……

   8.6. Diabetes (Yes☐ / No ☐) ……

   8.7. Cardiac issues (Yes☐ / No ☐) ……

   8.8. Psychological counselling if any (Yes☐ / No ☐) ……

   8.9. Any other major illness [specify] _____

   _____

   _____

   _____

   _____

   _____

9. Have you been vaccinated for Hepatitis B ?

   _____

10. Does any one in the family suffer from the following diseases?

10.1. Diabetes (Yes☐ / No ☐)…… Father / Mother / Others (Put tick mark where applicable)……

10.2. Epilepsy (Yes☐ / No ☐) …… Father / Mother / Others (Put tick mark where applicable)……

10.3. Tuberculosis (Yes☐ / No ☐)…… Father / Mother / Others (Put tick mark where applicable)……

10.4. Cardiac Problem (Yes☐ / No ☐) …… Father / Mother / Others (Put tick mark where applicable)……

DECLARATION BY THE APPLICANT

I declare that all the above information provided by me is true, and if found wrong, I forfeit my candidature for admissions.

Once I join Sri Sathya Sai Institute of Higher Learning (Deemed-to-be-University), I will not apply for any other programmes (at other institutions), without the prior permission of the Director of Campus of SSSIHL.

Date: _____ Signature of the applicant

MEDICAL CERTIFICATE FROM THE MEDICAL PRACTITIONER

This is to certify that I have examined Sri _____ thoroughly and found the above mentioned medical information to be true to the best of my knowledge.

Date: _____ Signature with Seal of the Medical Practitioner
