Sri Sathya Sai Institute of Higher Learning

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

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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] ____

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9. Have you been vaccinated for COVID-19/ Hepatitis B ? In case of COVID-19 vaccination, share the number of doses(s) you have taken and the time when they were taken.

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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

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