VISHWA BHARTI PUBLIC SCHOOL, Dwarka

The March Is On...

Circular No: VBPs/DWK/2026-27/14 Date: 27/07/2026

HEALTH AND MEDICAL SAFETY NOTICE

Dear Parent,

Consistent presence in school plays an important role in a child's learning journey. However, true learning can only happen when the child is physically fit. When an unwell student attends school, it not only hampers their own learning but may also put other children at risk of infection.

It has been noticed that some students come to school on examination days despite being unwell and then request to leave early. Please be informed that the school considers genuine medical cases (supported by a registered doctor's certificate) as per the policy.

Parents are requested to keep their ward at home if any of the following are observed:

1. Fever of 100°F or above.
2. Vomiting and/or loose motions, often accompanied by fever or loss of appetite.
3. Severe pain requiring strong medication.
4. Conjunctivitis (red eyes).
5. Unexplained, itchy or spreading rashes.
6. Any communicable disease.

Students should rejoin school only after the recommended recovery period and must present a medical fitness certificate issued by a registered doctor.

For quick and effective medical support during emergencies, the school needs accurate health records of each student. **Hence, parents of students with any medical history or health condition must fill in the attached Medical Information Form and submit it to the class teacher.**

Important Instructions:

- Students involved in school sports who are suffering from any infectious condition will be allowed to play only after they submit a Fitness certificate issued by a registered doctor.
- For minor cases, parents will be contacted to collect the child.
- Parents must keep emergency contact details updated and provide an alternate guardian's information in case they are out of station.

We sincerely seek your cooperation in ensuring the wellbeing of all children.

WISHING EVERY VISHWA BHARTIAN GOOD HEALTH!

Encl.: Medical information form

Prabha

Ms.Prabha Gupta
Principal

MEDICAL ALERT FORM

Please read the instructions given below carefully. Feel free to contact the school if you need any clarifications.

This document contains SIX pages as we have combined all FOUR medical forms into one to make it easier for parents to find them and fill them out. This ensures that the school has all necessary forms completed to maintain a safe and efficient process for all students.

Complete only the appropriate form(s) and submit them as soon as possible to comply with the School Health Policy.

Instructions:

- Read the description for each form and choose which applies to your child.
- Indicate which form(s) you need to complete by selecting the checkbox next to that form.

CHECKBOX Select all that applies	**FORM NAME** Click on form button to access from	**DESCRIPTION**	**PAGES**
☐	Medical Alert Form	Complete this form if your child has a medical condition that needs precautionary treatment or medication at school	1 to 2
☐	Request for Administration of medication	Complete this form ONLY if your child needs medication administered at school.	3
☐	Vaccination form (Mandatory for all PS & PP parents to fill)	Complete this form ONLY if your child needs an anaphylaxis emergency action plan*	4
☐	General Health Form	Complete this form ONLY if your child needs a diabetic action plan* at school	5 to 6

(The information collected on this form is subject to and protected by the provisions of the Freedom of Information and Protection of Privacy Act).

Medical Alert Form				**School Year:**	
Student 's Name:				Photo ID	
Class:					
Section:					
Date of Birth:					
Age					
Contact Name & Telephone Numbers					
Mother's / Guardian's Name:		Father's / Guardian's Name:			
Land line		Father's/Guardian's Office or Mobile No		Mother's/Guardian's Office or Mobile No	

Physician's Name		Phone Number	
Indicate what medical condition the student has that may require emergency care at school:			
Describe the potential problem (include symptoms that might be observed)			
Describe the necessary action or intervention to appropriately treat this medical condition:			
Step 1			
Step 2			
Step 3			
Step 4			
Step 5			
Is medication needed?			
If yes, what medication?			
Prescribing Physician:		Phone No	
Parents must complete a Request for Administration of Medication Form (section below) if their child needs medication administered at school in case of an emergency. **<u>Note</u>: No medication will be administered until this section of the medical form is completed. Parents need to ensure that the medication does not expire. It is the obligation of parents to keep a sufficient supply of any required medication at the school.**			

I have read and verified that the above information is correct.

Parent's / guardian's Name Signature Date

<u>Copy to:</u>

Student's Personal File
Medical Bay

REQUEST FOR ADMINISTRATION OF MEDICATION

Complete this section ONLY if your child needs medication administered at school.

☐	If changes occur, I will contact the school and provide revised instructions. I am aware I am required to update this information each April.
☐	I request that staff give medication as prescribed on this form to my child in case of an emergency.
☐	I agree to supply the medication to the school in the original container with the child's name, prescribing physician's direction for use including dosage.
☐	I am aware that the Doctor and Nurse for the school will be informed of my child's condition and medication; and that the Nurse may contact me as necessary.
☐	I am aware that staff and other personnel working with my child will need to know my child's condition and the medication required.

If training is required to administer the medication, please specify,

Training on:			
Trainer's Name		Training Date	
Name of Trained Person 1		Name of Trained Person 2	

Authorization – I agree to (select those that apply) :

☐	Supply the school with medications and up-to-date Epi-pen(s) /Inhaler
☐	Provide the child with a medic alert bracelet and fanny-pack for Epi-pen/Inhaler
☐	Ensure the child knows his/her responsibilities for his / her own safety
☐	Ensure the child will have an Epi-pen /Inhaler on their person. (It is strongly recommended that children have Epi-pens on their person at all times)
☐	I understand that my failure to do the above may result in an inability to implement timely emergency procedures for this potential life-threatening condition.
☐	I authorize the staff of VBPS Noida to execute the school's commitments as outlined within this plan.
☐	I am aware that the Doctor and Staff Nurse of VBPS (Noida) will be informed of my child's condition and treatment and that the Nurse may contact me as necessary.
☐	I give consent for the identification of the child as a person with _____ (nature of condition / risk).
☐	I understand that this may include the display of pertinent information, including a picture of the child in strategic locations within the school. It is understood that the person for this display is to enable the Staff of VBPS Noida to respond to potential emergencies in a timely fashion. It is clearly understood that student confidentiality will be maintained wherever possible.

Parent's / guardian's Name Signature Date

[To be submitted at the time of admission of the student]

VACCINATIONS

Name of the Student .....

M/F .....Class.....Section.....

Date of Birth ..... Blood Group .....

IMMUNIZATION	AGE RECOMMENDED	RECEIVED	
		YES	NO
BCG	0-1 Month		
Hepatitis B	At Birth		
	1 Month		
	6 Month		
DPT	2 Months		
	3 Months		
	4 Months		
HB	2 Months		
	3 Months		
	4 Months		
Oral Polio	At Births		
	1 Months		
	2 Months		
	3 Months		
	4 Months		
Measles	9 Months		
MMR	16 Months		
DPT+OPV+HIB	18 Months		
Typhoid	2 Years		
Hepatitis A (2 Doses)	2 Years		
Chicken Pox	After age 1 year		
DT – OPA	4½ Year		

BOOSTER DOSES

Typhoid (Every 3 years)	DATE	DATE	DATE
TT (Every 5 years)			
Other Vaccines			

Signature of Father .....Signature of Mother .....

GENERAL HEALTH FORM

TO BE CERTIFIED BY A REGISTERED MEDICAL PRACTITIONER

Name of the Student .....Class .....Academic Year .....

Date of physical examination.....Height .....Weight.....BMI .....

B.P..... Pulse ..... Vision (L) ..... (R) .....

Squint..... Conjunctiva..... Cornea.....Ear L..... R.....

CLINICAL EXAMINATION	NORMAL	RECOMMENDATION	REMARKS, IF ANY
Head/Neck			
Abdomen			
Surgery			
Serious Illness			
Nails			
Skin			

Summary of Current Health Condition:

_____

_____

Fit to Participate in all age specific physical activities including Swimming

_____

Fit to participate in age specific physical activities **with precautions**

_____

_____

Should not participate in competitive sports / activities involving a lot of physical activity

_____

Signature of Doctor .....

Name of the Doctor.....

Major Vaccines Received		
☐ BCG	☐ Oral Polio	☐ Cervical/Pineal
☐ DPT	☐ Covid 19	☐ Hepatitis -B
☐ MMR	☐ TT	

HIGH BLOOD SUGAR SYMPTOMS My child's symptoms at time of HIGH blood sugar reaction are usually:		
☐ Headache ☐ Drowsiness ☐ Behavior Change	☐ Frequent urge to urinate ☐ Nausea / stomach pain	☐ Excessive thirst ☐ Dry mouth

Others (Please Specify)		
☐ Epilepsy ☐ Allergy ☐ Asthma	☐ Over Weight ☐ Under Weight	

HIGH BLOOD SUGAR TREATMENT

If blood sugar is low /high: Notify the parents ☐

The school is not responsible for administering insulin

Authorization – I agree to (select those that apply):

☐	Provide emergency sugars and snacks for the treatment of low blood sugar.
☐	Keep a glucometer and adequate supplies for the monitoring of blood sugar levels for my child and ensure child is aware of safe disposal of sharps and supplies.
☐	If changes occur, I will contact the school and provide revised instructions. I am aware I am required to update this information as needed.
☐	I am aware that the Doctor and Staff Nurse of VBPS (Noida) will be informed of my child's condition and treatment and that the Nurse may contact me as necessary.
☐	I authorize the staff of school to execute the school's commitments as outlined within this place.
☐	I give consent for the identification of the child as a person _____(nature of condition / risk). I understand that this may include the display of pertinent information, including a picture of the child, in strategic locations within the school. It is understood that the reason for this display is to enable the staff to be able to respond to potential emergencies in a timely fashion. It is clearly understood that student confidentiality will be maintained wherever possible.
☐	I authorize the staff of VBPS (Noida) to administer the designated treatment and to provide suitable medical assistance. I agree to bear all costs associated with the medical treatment of my ward and absolve VBPS (Noida) and the Child Education Society of the responsibility for any adverse reactions resulting from the administration of the designated medication.

Parent / Guardian Name Signature Date