

THE ICFAI UNIVERSITY, HIMACHAL PRADESH
HEALTH CERTIFICATE TO BE FURNISHED BY A STUDENT
DULY SIGNED BY A MEDICAL OFFICER

Name of the Student: _____ Application No.: _____

Age: _____ Gender: Male/ Female Blood Group: _____

Height (in cms): _____ Weight: _____

Past history of Sickness, if any: (Brief description):

Personal Habits:

Smoking (Yes/No): _____ Alcohol (Yes/No): _____ Tobacco Chewing (Yes/No): _____

Any Other (Please Specify):

History of Allergies (if any):

Date:

Signatures of the Medical Officer

Place:

Name of the Medical Officer

Professional Seal