|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| First Name |  | | | |
| Last Name |  | | | |
| Address |  | | | |
| City/State/Zip |  | | | |
| Home Phone |  | | Cell Phone |  |
| Email |  | | | |
|  | | | | | |
| Provide the following details: | | | | | |
|  | |  | | | |
|  | |  | | | |
| |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | | Weight |  | Height |  | BP |  | | Blood Group |  | Lungs |  | Heart |  | | Vision | Left Eye: | Right Eye: | Details |  | | | Hearing |  | Any Impediment in Speech: | |  | | | Any Neurological / Psychiatric disease, (if yes, please give details). | | | |  | | | Suffering from Hepatitis B / Hepatitis C / HIV (AIDS) | | | |  | | | Any significant Disease Diagnosed in the past: | | | |  | | | Vaccinated (Yes/No/Partially). | | | |  |  | | Taking any medicine on regular basis (if yes, please give details). | | | |  |  | | Allergies if any: | |  | Any Communicable / Contagious Disease: | | | | Mark of Identification: | |  |  | | |   I certify that I have examined Mr/Ms who is an applicant for I.A.A. AeroCamp and could not notice that he / she has any physical or mental disease and is FIT for undertaking summer camp.  Signature of doctor with seal Signature of candidate   |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | |  |  | | |  |  |  |  |  | | | | | | |