

**SRI SIDDHARTHA DENTAL COLLEGE AND HOSPITAL, TUMKUR.**

**CONFIDENTIAL STUDENTS HEALTH PROFILE**

Sri Siddhartha Dental College ensures that the student in the dental program (BDS/MDS) will not be discriminated against on the basis of past or current health problems or handicap provided that neither endangers the well-being of patients or fellow students or hinders the student's ability to perform the functions required of a dental health professional.

Recent  
Passport size  
Photograph

**UNIVERSITY Reg. No. :**

**RGUHS / SSU SCHEME**

**STUDENT NAME:**

**Age:**                      **Sex:**                      **D.O.B:**

**Year of Study:**

**Batch:**    Regular / Supplementary

**Year of Joining:**

**Please provide information regarding your health conditions and give details of the same (if any):**

Sl.no	Health Condition	Details
1	Cardiac conditions	
2	Hypertension	
3	Epilepsy / neurological conditions	
4	Respiratory conditions	
5	Psychiatric conditions	
6	Diabetes	
7	Allergies (Include all known allergies) E.g.: Drug allergies, sensitivity to chemicals, dust, latex, etc	
8	Any other conditions	

- Are you on any regular medications (Prescription as well as over the counter): Yes / No.
  - If Yes, give details of the medication.
- Provide information of your addictive habits (If Any): Smoking / Alcohol / Drug Dependency.
- Provide information regarding inability to perform certain motions / Physical work limitations (If Any):
- History of immunization for hepatitis B: Yes / No (If No, then it is the duty of the candidate to get immunized immediately)

#### **DECLARATION BY THE CANDIDATE**

*I..... declare that the above given details are true to the best of my knowledge and if any untoward emergency/life threatening health incidents take place I shall not hold the college authorities responsible for the same.*

*I will update my health profile to the college authorities as and when it changes.*

*I hereby grant the college authorities permission to contact any physician(s) or other professional(s) to evaluate/treat my health condition if required*

*Date:*

*Signature of the Student*

#### **DECLARATION BY THE PARENT/GUARDIAN**

**If guardian, please mention the relationship with the student:**

*I.....father/mother/guardian of..... declare that the above given details of my ward, are true to the best of our knowledge and if any untoward emergency/life threatening health incidents take place we shall not hold the college authorities responsible for the same.*

*I will update my wards health profile to the college authorities as and when it changes.*

*I hereby grant the college authorities permission to contact any physician(s) or other professional(s) to evaluate/treat my wards health condition if required*

*Date:*

*Signature of the Parent/Guardian*