*Annexure V*

**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