

MEDICAL CERTIFICATE

1. It is certified that Master/Miss _____ Age _____ (Years)
Son/daughter of _____ Address _____
_____ is not suffering from my disease OF has been in
contact with any contagious disease.

2. He/She has been given protective Inoculation/Vaccination as under :
Protective Inoculation/Vaccination date

- (a) Small Pox Vaccination _____
- (b) Triple Antigen (upto 5 yrs) _____
- (c) TAB _____
- (d) Tetanus Toxoid _____

Officer

Dated _____

Signature of Medical

No. _____
Name & Full Address