



MINISTRY OF HEALTH AND FAMILY WELFARE, GOVERNMENT OF INDIA NATIONAL BUREAU OF MATERNAL AND CHILD HEALTH NATIONAL BUREAU OF MATERNAL AND CHILD HEALTH

Name: _____ Roll No: _____
 Date: _____ Page: _____
 Subject: _____

1. Name of the child: _____
 2. Date of birth: _____
 3. Sex: _____
 4. Age: _____
 5. Height: _____
 6. Weight: _____
 7. Blood group: _____
 8. Address: _____
 9. Occupation: _____
 10. Education: _____

Sl. No.	Particulars	Remarks	Signature	Date
1	1. Name of the child	_____	_____	_____
2	2. Date of birth	_____	_____	_____
3	3. Sex	_____	_____	_____
4	4. Age	_____	_____	_____
5	5. Height	_____	_____	_____
6	6. Weight	_____	_____	_____
7	7. Blood group	_____	_____	_____
8	8. Address	_____	_____	_____
9	9. Occupation	_____	_____	_____
10	10. Education	_____	_____	_____
11	11. Signature of the parent/guardian	_____	_____	_____
12	12. Signature of the doctor	_____	_____	_____
13	13. Signature of the nurse	_____	_____	_____
14	14. Signature of the health worker	_____	_____	_____
15	15. Signature of the community health worker	_____	_____	_____
16	16. Signature of the health officer	_____	_____	_____
17	17. Signature of the health supervisor	_____	_____	_____
18	18. Signature of the health officer-in-charge	_____	_____	_____
19	19. Signature of the health officer-in-charge	_____	_____	_____
20	20. Signature of the health officer-in-charge	_____	_____	_____

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