



वसुधैव कुटुम्बकम् ॥ **SYMBIOSIS CENTRE OF HEALTH CARE (SCHC)**

**Registration Form
H1 N1 Vaccination**

Name:- _____ Sex :- M F

Age :- _____

Address:- _____

Phone :- _____ E – mail ID :- _____

Institute / School / College:- _____

Campus:- _____

Medical History

1 . Hypersensitivity to:- Eggs	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Gentamycin	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Previous Influenza Vaccine	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
2. Presently Suffering from High Fever	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
3. History of Asthma / Recurrent Wheeze:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
4. Presently on:- Aspirin	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Steroid	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Chemotherapy	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Antibiotics	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

Note:- For further Clarification Please call SCHC on 020 – 256 55362