INSTITUTE OF TECHNOLOGY MADRAS

SCHEDULE OF EVENTS

(B.TECH, DUAL DEGREE & B.S – Medical Science & Engineering)

<table>
<thead>
<tr>
<th>SCHEDULE OF EVENTS</th>
<th>DATE</th>
<th>Time</th>
<th>VENUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document Verification</td>
<td>25.07.2023</td>
<td>09.00 am onwards</td>
<td>Student Activity Centre (SAC)</td>
</tr>
<tr>
<td>Commencement of Classes</td>
<td>31st July, 2023</td>
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GENERAL GUIDELINES / INSTRUCTIONS FOR DOCUMENT VERIFICATION

Students should produce the following documents in original during Document Verification compulsorily. (No Photocopies are required)

1. 10th Class and 12th Class Marksheet. If your date of birth is not mentioned in the 10th marksheet, bring your Birth Certificate.
2. Category Certificate (GEN-EWS, OBC-NCL, SC, ST – If applicable)
3. PwD Certificate (if applicable)
4. Proof of certificate for OCI
5. Passport & Visa (for Foreign National only)
6. JEE Admit Card
7. JOSAA Seat acceptance letter
8. Income certificate (whose parental income is upto 8 Lakhs per annum) obtained from Tasildhar, Revenue Department
9. Medical Certificate as per Annexure I
10. Welcome Letter from IITM JEE Office
Medical Examination Report

Medical History and personal particulars of Students joining at IIT Madras

Name of the Candidate (in Full):.................................................................
JEE (Advanced 2023) /IAT Registration Number......................... IIT M Roll Number.................................
Name of the Parent/Guardian.................................................................

1. Do you suffer from any allergies including Drug Allergy    Yes / No
   If yes Specify____________________________________________________

2. Do you have any medical problems (circle as appropriate) : Heart disease / diabetes / Thyroid / Skin disease / Bronchial asthma/Seizure Disorder or Epilepsy/Others (specify)
   Yes / No
   If yes give details________________________________________________

3. Are you able to see well                                                   Yes / No
   If there is a visual defect has it been corrected by suitable Spectacles Yes / No

4. Do you suffer from any hearing disability        Yes / No

5. Do you suffer from any loco motor or movement disorder or any loss of body part
   Yes / No
   If Yes Details____________________________________________________

6. Are you currently on any long term medications or have a history of
   long term (>2months) use of medication     Yes / No
   If yes details____________________________________________________________________

7. Any history of surgeries in the past                           Yes / No
   If yes details____________________________________________________________________

Identification Marks

1. __________________________________________________________________________
2. __________________________________________________________________________

I declare that all the statements above are true, correct and complete to the best of my knowledge. I fully understand that I am responsible for the accuracy of all the statements given.

Date:                                                                 Candidate’s Signature: ................................
Place:                                                                Parent/Guardian’s Signature: ..............................
Health Certificate

Clinical Examination by a general Physician.

Weight .......... Kg. Height .......... cm. Blood Pressure ............. / ........mm Hg.

Girth of Chest: (a) At rest ...................... (b) After deep inspiration ......................

Pulse Rate: ............ per minute BP .............mmHg

Eye Test: Vision - Normal/Defective Corrected by Spectacles: Yes/No

ENT: Hearing (Whisper Test): Normal/Defective

Nose .............. Throat ......................

Respiratory System: ...................... Cardiovascular System: ..............

Neurological System: ......................

Psychological Assessment: ...................... Abdomen: ......................

Past Medical / Surgical history: -

H/o Allergy Yes / No Current Medications if any: -

<table>
<thead>
<tr>
<th>Vaccination Details</th>
<th>No. of doses</th>
<th>Date of Last Injection</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. BCG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Diphtheria/Pertussis/Tetanus (DPT)</td>
<td></td>
<td></td>
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<tr>
<td>3. Mumps, Measles, Rubella</td>
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<td>4. Hepatitis B</td>
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<td>5. Typhoid</td>
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<td>6. Chicken Pox</td>
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<td>7. Covid 19 Vaccination</td>
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Investigations

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<thead>
<tr>
<th>Name of the Investigation</th>
<th>Remarks/Report with date</th>
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</thead>
<tbody>
<tr>
<td>1. ECG</td>
<td></td>
</tr>
<tr>
<td>2. Chest X-Ray</td>
<td></td>
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Blood Test/ Urine Test

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<thead>
<tr>
<th>Name of the Investigation</th>
<th>Remarks/Report with date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Blood Group &amp; Rh Typing</td>
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</tr>
<tr>
<td>2. Hemoglobin</td>
<td></td>
</tr>
<tr>
<td>3. Peripheral Smear</td>
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<tr>
<td>4. Random Blood Sugar</td>
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<tr>
<td>5. Serum Creatinine</td>
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</tr>
<tr>
<td>6. HIV – 1 &amp; 2</td>
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<tr>
<td>7. HBsAg</td>
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<tr>
<td>8. Urine Routine examination</td>
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Dr. ..........................................................................................after clinical assessment (with necessary investigations) of
Mr/Ms. .......................................................................................... Son/Daughter of Mr/Ms.
.......................................................................................... declare him/her fit/unfit, mentally and physically to pursue higher education
with a very tight academic schedule. I further declare that he/ she does not suffer from seizure disorder or any other major
medical illness preventing him/her from undertaking sports including swimming.

Date:                                                 Signature & Seal
Place: