Children's Medical Report

METROLINA CHRISTIAN ACADEMY ESTABLISHED 1992 Early Education

Name of Child: _____ Birthdate: _____

Name of Parent(s) or Guardian(s): _____

Address of Parent(s) or Guardian(s): _____

_____

A. Medical History (May be completed by parent)

1. Is child allergic to anything? No ____ Yes ____ If yes, what? _____

_____

2. Is child currently under a doctor's care? No ____ Yes ____ If yes, for what reason? _____

_____

3. Is the child on any continuous medication(s)? No ____ Yes ____ If yes, what? _____

_____

4. Any previous hospitalizations or operations? No ____ Yes ____ If yes, when and for what? _____

_____

5. Any history of significant previous disease(s) or recurrent illness(es)? No ____ Yes ____

diabetes No ____ Yes ____; convulsions No ____ Yes ____; heart trouble No ____ Yes ____

If others, what/when? _____

6. Does the child have any physical disabilities? No ____ Yes ____ If yes, please describe: _____

_____

Any mental disabilities? No ____ Yes ____ If yes, please describe: _____

_____

Signature of Parent/Guardian: _____ **Date:** _____

B. Physical Examination: This examination must be completed and signed by a licensed physician, his/her authorized agent currently approved by the NC Board of Medical Examiners (or a comparable board from bordering states), a certified nurse practitioner, or a public health nurse meeting DEHNR standards for EPSDT program.

Height _____% Weight _____%

Head _____ Eyes _____ Ears _____ Nose _____ Teeth _____

Throat _____ Neck _____ Heart _____ Chest _____ Abd/GU _____

Ext _____ Neurological System _____ Skin _____

Results of Tuberculin Test, if given: Type _____ Date _____ Normal ____ Abnormal ____

Should activities be limited? No ____ Yes ____ If yes, explain: _____

_____

Any other recommendations: _____ Date of Exam:

_____ _____

Signature of authorized examiner/title: _____ **Phone#:** _____

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Immunization History

Name: _____ Birthdate: _____

Enter the date an immunization was received in the space below or attach a copy of the immunization records. G.S. 130A-155(b) requires all child care facilities to have this information on file.

VACCINE	#1	#2	#3	#4	#5
DTP/DT* (Circle Which)					
Polio*					
Hib**					
Hepatitis B***					
MMR* (Combined Doses)					
Varicella****					
OTHER					
OTHER					
OTHER					

* Required by State Law
** Require by State Law for children born on or after October 1st, 1988.
*** Require by State Law for children born on or after July 1st, 1994.
**** Require by State Law for children born on or after April 1st, 2001.

Records Updated By:	Date Updated: