CHILDREN'S MEDICAL REPORT

Name of Child _____ Age _____ Birthdate _____
Name of Parent or Guardian _____
Address of Parent or Guardian _____
MEDICAL HISTORY: (May be completed by parent)

1. Previous hospitalization? Yes _____ No _____
   If so, why? _____
2. Is child allergic to anything? Yes _____ No _____
   If so, what? _____
3. Any previous diseases or illness? Yes _____ No _____
   If so, what? _____
4. Any operations? Yes_____ No _____
   If so, what type? _____
5. Any physical handicaps? Yes _____ No _____
   If so, please describe: _____
6. Is child under the care of a doctor? Yes _____ No _____
   If so, for what reason? _____
7. Any history of mental retardation? Yes _____ No _____
8. Any history of convulsions? Yes _____ No _____
9. Any history of diabetes in family? Yes _____ No _____
10. Any history of heart trouble? Yes _____ No _____

_____

(Parent/Guardian Signature)

PHYSICAL EXAMINATION: This examination must be completed and signed by a licensed Physician or his or her authorized agent who is currently approved by the N.C. Board of Medical Examiners.

Weight _____ Height _____ Heart _____

Chest _____ Throat _____ Neck _____ Abdomen _____ GU _____ Ext _____
Neurological System _____
Teeth _____ Skin _____ Head _____ Eyes _____ Ears _____
Results of Tuberculin Test, if given: _____
(Type) (Results)
Should activities be limited? _____
Recommendations: _____

_____ _____

(Signature of physician or authorized agent who is currently approved by the NC Board of Medical Examiners)

Date of examination

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