417 N. Main Street
China Grove, NC 28023
85-LEARN (855-3276)

PHYSICAL / MEDICAL REPORT & SHOT RECORD RELEASE

To: Doctor's Office ______ Phone # ______ Fax # ______

From: Parent's Name (Last, First) ______

C/O: South Rowan Academy of Child Development

Fax to: 704-855-0823

Re: Child's Name ______ Date of Birth ______

Child's Name ______ Date of Birth ______

Child's Name ______ Date of Birth ______

My child(ren) (named above) is/are enrolled at South Rowan Academy of Child Development. I hereby authorize you to release to them a completed medical report/physical, and/or a Food Allergy and/or Immunization Report. This may be your own form or the document included here.

Thank you!

Signature of Parent / Guardian ______ Date ______

Signing Parent's Printed Name ______

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CHILDREN'S MEDICAL REPORT (TO BE PRINTED OUT, COMPLETED BY A LICENSED PHYSICIAN, AND RETURNED TO SOUTH ROWAN ACADEMY)

Name of Child (Last, First, Middle)*

Date of Birth*

Parent / Guardian's Name*

Parent / Guardian Address, Apt #*

City*

State*

Zip Code*

MEDICAL HISTORY

Yes No Is the child allergic to anything?* If yes, what (use N/A if not applicable)?*

Yes No Is child currently under a doctor's care?* If yes, for what reason (use N/A if not applicable)?*

Yes No Is the child on any continuous medication?* If yes, what (use N/A if not applicable)?*

Yes No Any previous hospitalizations or operations?* If yes, when and for what (use N/A if not applicable)?*

Yes No Significant previous disease or recurrent illness?* If yes, when and for what (use N/A if not applicable)?*

Yes No Diabetes?* Yes No Convulsions* Yes No Heart Trouble?*

Yes No Any mental disabilities?* If yes, please describe (use N/A if not applicable)*

Signature of Parent / Guardian*

Date*

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

SHOT RECORD MUST BE ATTACHED AND SUBMITTED WITH THIS FORM 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 Examination _________________

Signature of Authorized Examiner____ Title____