## 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_____