

Wilson Christian Academy

Child Care Center

Medical Report

Name of Child _____ Birthdate _____

Name of Parent or Guardian _____

Address of Parent or Guardian _____

A. Medical History (May be completed by parents)

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? No ___ Yes ___ If yes, when and what for? _____

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

5. Any history of significant previous diseases or recurrent illness, diabetes, convulsions, heart trouble, other? No ___ Yes ___ Explain _____

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

Does the child have any mental disability? No ___ Yes ___ If yes, please describe: _____

B. **Physical Examination:** This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the N.C. 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 _____ Skin _____

Neurological System _____

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

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

Any other recommendations: _____

Signature of authorized examiner/title _____

Phone# _____ Date of examination: _____