Columbus Christian Academy

"Educational Excellence for Christ"

Children's Medical Report

Name of Child _____ Birthdate _____
Name of Parent or Guardian _____
Address of Parent or Guardian _____

A. Medical History (May be completed by the 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? 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 diseases or recurrent illness? No ___ Yes ___; Diabetes? No __Yes ___; Convulsions? No ___ Yes ___; Heart trouble? No ___ Yes ___; Asthma? No ___ Yes ___
6. Does the child have any physical disabilities? No ___ Yes ___ If yes, please describe: _____
   _____
7. Any mental disabilities? No___ Yes ___ If yes, please describe: _____
   _____

Signature of Parent or Guardian _____Date_____

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 DHHS standards for SPSDT program.
Height _____% Weight _____%

Head _____ Eyes_____ Ears _____ Nose _____ Teeth _____ Throat_____
Neck _____Heart_____Chest_____Abd/GU_____Ext_____
Neurological System _____Skin_____Vision_____Hearing_____
Results of Tuberculin test, if given: Type_____Date:_____Normal___Abnormal___Follow-up_____

Developmental Evaluation: Delayed_____Age Appropriate_____
If delay, note significance and special care needed: _____
_____

Should activities be limited? No ___ Yes___ If yes, explain: _____
Any other recommendations? _____

Date of Examination: _____

Signature of authorized examiner/title _____Phone # _____