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St. John's Lutheran School
Developing Minds. Serving Communities. Growing In Faith.

Child's Medical Report

Name of Child _____ Date of Birth _____/_____/_____
Name of Parent/Guardian _____
Address of Parent/Guardian _____
_____

I. MEDICAL HISTORY (may be completed by parent)
Does the child have any allergies? ___ Yes ___ No If yes, what? _____
_____
Is child currently under a doctor's care? ___ Yes ___ No If yes, for what reason_____
_____
Is the child on any continuous medication? ___ Yes ___ No If yes, what? _____
_____
Any previous hospitalizations or operations? ___ Yes ___ No If, yes, when and for what? _____
_____
Any history of significant previous diseases or recurrent illness? ___ Yes ___ No
Diabetes ___ Yes ___ No Convulsions ___ Yes ___ No Heart Trouble ___ Yes ___ No
If others; what/when? _____
Does child have any physical disabilities? ___ Yes ___ No If yes, please describe _____
_____
Does child have any mental disabilities? ___ Yes ___ No If yes, please describe _____
_____
Signature of Parent/Guardian _____ Date _____

II. PHYSICAL EXAMINATION: This examination must be completed and signed by a licensed physician, or his authorized agent currently approved by the NC 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 ___Yes ___ No
Should physical activities by limited? ___ Yes ___ No If yes, please explain _____
_____
Any other recommendations: _____
Signature of authorized examiner & title _____
Date of examination_____ Office phone _____
Office address (may use stamp)_____

*** * * * *PLEASE ATTACH RECORD OF CHILD'S IMMUNIZATIONS * * * * ***