Kindergarten - 5th Grade

Child's Medical Report

St. John's Lutheran School

Developing Minds. Serving Communities. Growing In Faith.

Date of Report:______________________

Name of Child ________________________________ Birth Date ______________________

Name of Parent/Guardian ____

Address of Parent/Guardian ____

____

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 ________________

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 be 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 * * * * ***