



## Medical Report 2010-11 – ELEMENTARY STUDENT

Name of Child \_\_\_\_\_ Birth date \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

### A. Medical History (To be completed by 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 child on any continuous medication? No\_\_\_ Yes\_\_\_ If yes, what? \_\_\_\_\_

**\*\*If your child will need to take medication during school hours, please request a 'permission to administer medication' form from the office.\*\***

4. Any previous hospitalizations or operations that the school should be aware of? No\_\_\_ Yes\_\_\_  
If yes, when and for what? \_\_\_\_\_

5. Any history of significant previous diseases or recurrent illness? No\_\_\_ Yes\_\_\_ If yes, please describe:

Diabetes No\_\_\_ Yes\_\_\_      convulsions No\_\_\_ Yes\_\_\_      heart trouble No\_\_\_ Yes\_\_\_

If others, what and when? \_\_\_\_\_

**6. Does child have any physical limitations or disabilities that would prevent him/her from participating in physical education class or activities?: No\_\_\_ Yes\_\_\_**  
**If yes, please describe and provide documentation from physician.**

7. Does child have any mental disabilities? No\_\_\_ Yes\_\_\_ If yes, please describe:

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### IMMUNIZATION RECORDS

*If your child is a returning student and has not had any immunizations since August of 2009, the record on file will suffice.*

*If/when new immunizations are administered, please obtain a copy for the school and turn in promptly.*

### FOR RISING 6<sup>TH</sup> GRADERS:

**\*\*NC DHHS requires Rising 6<sup>th</sup> Graders to receive a booster dose of the Tdap vaccine. Please see enclosed flyer for more information and ensure that your child receives this booster. State regulations require that the child's immunization record reflecting this vaccination is in the student's file.**