



## Medical Report 2010-11 – Toddler & Children’s House

**Bottom portion must be filled in and signed by your child’s doctor**

Name of Child \_\_\_\_\_ Birthdate \_\_\_\_\_

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

### A. Medical History (May 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 needs to take medication during school, please request a permission form from the office.**

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\_\_\_

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

6. Does child have any physical disabilities: No\_\_\_ Yes\_\_\_ If yes, please describe: \_\_\_\_\_

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

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

**B. Doctor’s Physical Examination:** This examination must be completed and signed by a licensed physician, his/her authorized agent currently approved by the N.C. Board of Medical Examiners, a certified nurse practitioner, or a public health nurse meeting DEHNR standards for EPSDT program.

**Returning students: Your child’s exam/report must be no more than 1 year old.**

Height \_\_\_\_\_ Weight \_\_\_\_\_

Head \_\_\_\_\_ Eyes \_\_\_\_\_ Ears \_\_\_\_\_ Nose \_\_\_\_\_

Teeth \_\_\_\_\_ Throat \_\_\_\_\_ Neck \_\_\_\_\_ Heart \_\_\_\_\_ Chest \_\_\_\_\_

Abd/GU \_\_\_\_\_ Ext \_\_\_\_\_ Neurological System \_\_\_\_\_ Skin \_\_\_\_\_

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

Should activities be limited? No\_\_\_ Yes\_\_\_ If yes, explain: \_\_\_\_\_

Any other recommendations: \_\_\_\_\_

→Examiner/title Print and Sign \_\_\_\_\_

Office Phone # \_\_\_\_\_ →Date of Examination \_\_\_\_\_

**✓ PLEASE SEND IN IMMUNIZATION RECORD WITH MOST RECENT VACCINATIONS ✓**  
**If your returning student has not had any immunizations since August of 2009, there is no need to obtain a vaccination record.**  
**When new vaccinations are administered, an updated record is required for the school file.**