



## Children's Medical Report Summer Fun

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 will need to take medication during school hours, please see the Emergency and Health form in your packet to fill out appropriate information.*

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. 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 (or a comparable board from bordering states), a certified nurse practitioner, or a public health nurse meeting DEHNR standards for EPSDT program.

**The child named below will be attending Summer Camp and will have activities indoor and out. Please note below if there are any conditions of which the School should be aware or that would limit his/her activities.**

### PLEASE ATTACH IMMUNIZATION RECORD TO THIS REPORT

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 \_\_\_\_\_