



building blocks

early education centers

Build them **RIGHT**, from the Start!

1428 Ireland Dr • Fayetteville, NC 28304 • (910) 483-7564 Office • www.fayettevillechristian.com

Children's Medical Report

Name of Child _____ Birth date _____

Name of Parent/Guardian _____

Address of Parent/Guardian _____

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 the child on any continuous medication? No ___ Yes ___ If Yes, what? _____
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/when? _____
6. Does the child have any physical disabilities? No ___ Yes ___ If Yes, please describe _____
7. Does the child have any mental disabilities? No ___ Yes ___ If Yes, please describe _____

Signature of Parent/Guardian _____ Date _____

B. Physical Examination *This examination must be completed and signed by a licensed physician, his 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.*

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: _____

_____ Date of Examination _____

Signature of Authorized Examiner/Title _____ Phone _____