# CHILDREN'S MEDICAL REPORT

METROLINA
CHRISTIAN ACADEMY
ESTABLISHED 1992

Name of Child ____________________ Birth Date ____________________

Name of Parent or Guardian ____________________ Parent or Guardian Phone Number ____________________

Street Address ____________________ City __________ State ______ Zip Code ______

## A. Medical History *(May be completed by parent.)*

1. Is the child allergic to anything? ☐ No ☐ Yes If yes, what?____________________
2. Is the child currently under a doctor's care? ☐ No ☐ Yes If yes, for what reason? ____________________
3. Is the child on any continuous medications? ☐ 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 disease or recurrent illness? ☐ No ☐ Yes

   Diabetes ☐ No ☐ Yes  Convulsions ☐ No ☐ Yes  Heart trouble ☐ No ☐ Yes
6. Does the child have any physical disabilities? ☐ No ☐ Yes If yes, please describe: ____________________

   Any medical disabilities? ☐ No ☐ Yes If yes, please describe: ____________________

Signature of Parent or Guardian ____________________ Date ____________________

## B. Physical Examination

***This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the NC Board of Medical Examiners (or comparable board from bordering states), a certified nurse practitioner, or a public health nurse meeting DEHBR standards for EPSDT program.***

Head _______ Eyes _______ Ears _______ Nose ______ Teeth _______ Throat _____

Neck _______ Heart _______ Chest _______ 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: ____________________

Signature of authorized examiner\title ____________________

Date of Examination ____________________

**Office Address**

*(may use address stamp)*

# IMMUNIZATION HISTORY

METROLINA CHRISTIAN ACADEMY
ESTABLISHED 1992
AD MAIOREM DEI GLORIAM

______________________________ ______________________
Name of Child Birth Date

**Enter the date an immunization was received in the space below or attach a copy of the immunization records. G.S. 130A-155(b) requires all child care facilities to have this information on file.**

**Enter date of each dose – Month/Day/Year**

| VACCINE | #1 | #2 | #3 | #4 | #5 |
|---|---|---|---|---|---|
| *DTP/DTaP *(Circle Which)* | | | | | |
| *Polio | | | | | |
| **Hib | | | | | |
| ***Hepatitis B | | | | | |
| *MMR *(combined doses)* | | | | | |
| ****Chicken Pox (Varicella) | | | | | |
| Other:______________________ | | | | | |
| Other:______________________ | | | | | |
| Other:______________________ | | | | | |

*Required by State Law.

** Required by State Law for children born on or after 10/01/1988.

***Required by State Law for children born on or after 07/01/1994.

****Required by State Law for children born on or after 01/01/2001.

| RECORDS UPDATED BY | DATE UPDATED |
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