Calvary Christian School – Children's Medical Report Form

(Parents/Guardians, please fill out Section A and have your child's doctor fill out Section B and attach an updated copy of your child's updated immunization records).

Child's Name:_______________________________________ **Date of Birth:**___________________________
Name of Parent/Guardian:____
Address of Parent/Guardian: Street____
City__________________________________ State________________ Zip______________________

Section A – Medical History (must be completed by parent/guardian):

1. **Is child allergic to anything? Circle One: Yes No If yes, what?**________________________________
   ____
2. **Is child currently under a doctor's care? Circle One: Yes No If yes, for what reason?**_____________
   ____
3. **Is child on any continuous medication? Circle One: Yes No If yes, what?**______________________
   ____
4. **Any previous hospitalizations or operations? Circle One: Yes No If yes, when and for what?**______
   ____
   ____
5. **Any history of significant previous diseases or recurrent illness? Circle One: Yes No**
   Convulsions? Circle One: Yes No Heart Trouble? Circle One: Yes No
   If others, what/when?____
   ____
6. **Does child have any physical disabilities? Circle One: Yes No If yes, please describe:**_____________
   ____
   ____
7. **Does child have any mental disabilities? Circle One: Yes No If yes, please describe:**______________
   ____
   ____
8. **If applicable, has your rising preschooler or kindergartener had all the necessary vaccines?**
   Circle One: Yes No N/A **All Preschool/Kindergarten vaccines are required for your child to enter school. Please provide updated immunization records as proof of these before the first day of school.*
9. **If applicable, has your rising 7th grader had a T-Dap vaccine within the last five years and a Meningococcal Conjugate Vaccine (MCV)? Circle One: Yes No N/A**
   **T-dap and MCV are required for your child to enter 7th Grade. Please provide updated immunization records as proof of these before the first day of school.*

   Parent/Guardian Signature:____

Section B – Physical Examination: This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the North Carolina Board of Medical Examiners (or a comparable board from boarding states), a certified nurse practitioner or public health nurse meeting DEHNR standards for EPSDT program.

Head___________ **Eyes**____________ **Ears**____________ **Nose**____________ **Teeth**____________
Throat__________ **Neck**____________ **Heart**____________ **Chest**___________ **GU**___________
Extrem._______________ **Neurological System**__________________ **Skin**__________________
Result of Tuberculin Test (if given): Type_______________________ **Date**_____________________
Normal______ Abnormal_______
Should activities be limited (circle one)? Yes No If yes, explain:_________________________________
____
Any other recommendations? ____
____
Signature of authorized examiner/title:____
Date of examination:________________________________ **Phone:**__________________ **Fax:**__________________

****Doctor's office must stamp this form with the practice name, address and phone number to provide proof that Section B was completed by a licensed physician or other authorized persons mentioned above.***