Child's Medical Report

Must be returned by 1st day of school

TO BE COMPLETED BY PARENT

Name of Child: _____ Birth Date: ____ / ____ / ____

Name of Parent/Guardian: _____

Address of Parent/Guardian: _____

TO BE COMPLETED BY PHYSICIAN

This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the NC Board of Medical Examiners (or a comparable board from another state), a certified nurse practitioner, or a public health nurse.

Are immunizations current? Yes ____ No ____ If no, please explain: _____

Please attach a copy of immunization record.

Weight_____ Height_____ Head____ Eyes____ Ears____ Nose____ Throat____ Neck____ Chest ____

Teeth ____ Skin ____ GU _____ Heart ____ Extremities ____ Heart ____ Neurological system ____

Developmental Evaluation: Delayed ____ Age appropriate ____ If delayed, note significance and special needs:

_____

Does child have any chronic conditions? _____

Should physical activities be limited? ____ If yes, please explain: _____

Any other recommendations? _____

_____ _____

Physician/Examiner Signature **Date of Examination**

_____ _____

Name of Physician/Examiner (print) **Office Phone**

_____

Office Address

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