

Children's Academy

CHILD'S MEDICAL REPORT

NAME OF CHILD _____ AGE _____ BIRTHDAY _____
NAME OF PARENTS _____
ADDRESS OF PARENTS _____

MEDICAL HISTORY

1. PREVIOUS HOSPITALIZATION? YES ___ NO ___ IF SO, WHY? _____
2. IS CHILD ALLERGIC TO ANYTHING? YES ___ NO ___ IF SO, WHAT? _____
3. ANY PREVIOUS DISEASES OR ILLNESS? YES ___ NO ___ IF SO, WHAT? _____
4. ANY OPERATIONS? YES ___ NO ___ IF SO, WHAT? _____
5. ANY PHYSICAL HANDICAPS? YES ___ NO ___ IF SO, PLEASE DESCRIBE _____
6. IS THE CHILD UNDER THE CARE OF A DOCTOR? YES ___ NO ___ IF YES, WHAT REASON _____
7. ANY HISTORY OF MENTAL RETARDATION? YES ___ NO ___
8. ANY HISTORY OF CONVULSIONS? YES ___ NO ___
9. ANY HISTORY OF DIABETES IN THE FAMILY? YES ___ NO ___
10. ANY HISTORY OF HEART TROUBLE? YES ___ NO ___

PARENT SIGNATURE

PHYSICAL EXAMINATION (MUST BE COMPLETED AND SIGNED BY EXAMINING PHYSICIAN)

WEIGHT _____ HEIGHT _____ HEART _____
CHEST _____ THROAT _____ NECK _____ ABDOMEN _____
GU _____ EXT. _____ NEUROLOGICAL SYSTEM _____
TEETH _____ SKIN _____ HEAD _____ EYES _____
EARS _____ RESULTS OF TB (IF GIVEN) _____
SHOULD ACTIVITIES BE LIMITED _____
RECOMMENDATIONS _____

IMMUNIZATION HISTORY (ENTER MM/DD/YY)

DTP 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
POLIO 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
MMR 1. _____ 2. _____ OR DATES OF INDIVIDUAL SHOTS
HIB 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
HEP 1. _____ 2. _____ 3. _____ 4. _____ 5. _____
TB 1. _____ 2. _____
VARICELLA (CHICKEN POX) 1. _____

PHYSICIAN SIGNATURE

NAME OF OFFICE

DATE OF EXAMINATION

OFFICE PHONE

OFFICE ADDRESS