



# Charlotte Jewish Day School

5007 Providence Rd. Building E Suite 110 Charlotte, NC 28226 704-366-4558

**2010 - 2011**

**CHILDREN'S MEDICAL REPORT**

Student's Name \_\_\_\_\_ Birth date \_\_\_\_\_

Parent's Name \_\_\_\_\_

Address of Parent \_\_\_\_\_ Phone \_\_\_\_\_

**A. Medical History** (To 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? \_\_\_\_\_
- 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 illnesses: 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: \_\_\_\_\_

**Signature of Parent or Guardian** \_\_\_\_\_

**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:

Head \_\_\_\_\_ Eyes \_\_\_\_\_ Ears \_\_\_\_\_ Nose \_\_\_\_\_ Teeth \_\_\_\_\_ Throat \_\_\_\_\_  
 Neck \_\_\_\_\_ Heart \_\_\_\_\_ Chest \_\_\_\_\_ Abd/GU \_\_\_\_\_ Ext \_\_\_\_\_ Neurological System \_\_\_\_\_ Skin \_\_\_\_\_  
 Results of Tuberculin Test: Type \_\_\_\_\_ Date \_\_\_\_\_ Normal \_\_\_\_\_ Abnormal \_\_\_\_\_  
 Should activities be limited? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, explain:

\_\_\_\_\_  
\_\_\_\_\_

Any other recommendations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signature of Authorized Examiner/Title** \_\_\_\_\_

Date of Examination \_\_\_\_\_ Phone \_\_\_\_\_

Name of child \_\_\_\_\_

**C. Immunization History:**

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

VACCINE	#1	#2	#3	#4	#5
*DTP/DT (circle which)					
*Polio					
**Hib					
*MMR (combined doses)					
Measles (single dose)					
Mumps (single dose)					
Rubella (single dose)					
Hepatitis B					
Varicella					
Tetanus					
Other					

\*Required by State law. \*\*Required by State law for children born on or after 10/1/91.

The Children's Medical Report must be submitted before June 1 to **Charlotte Jewish Day School, P.O. Box 79180, Charlotte, NC 28271-7059**