Little Hedgepeth Academy

Rocky River Campus

2400 Rocky River Road
Charlotte, NC 28213
(704) 599-KIDS

"We care when you can't be there."

CHILDREN'S MEDICAL REPORT

To Be Completed and Placed on File Prior to Enrollment

Name of Child: ______________________________ Date of Birth: ____________

Last First Middle Nickname

Name of Parent or Guardian: ______________________________

Last First Middle

Address: ______________________________

Street City State Zip Code

A. MEDICAL HISTORY (May 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 reason? ______________________________
3. Is 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 recent illness? 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: ______________________________
   Any mental 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. Height ________% Weight ________ %

Head ____________ Eyes ____________ Ears ________________ Nose ____________ Teeth ______________

Throat ___________ Neck ____________ Heart ________________ Chest ____________ Abd/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 ______________________ Phone # ______________________

Office Address
(may use address stamp)

(Continued on Back)

C. IMMUNIZATION HISTORY:
The day care operator or health official must enter the date immunization was received in the space below or attach a copy of the immunization record .

G.S. 130A-155(b) requires all day care facilities to have this information on file.

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

* Required by State law

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