Sunrise Children's School

MEDICAL REPORT

(TO BE COMPLETED BY A PHYSICIAN)

Name of child _____ Birth date _____

Name of Parent/Guardian _____ Phone _____

Address of Parent/Guardian _____

A. Medical History

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 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. _____

_____

7. Does the child have any mental disabilities? No _____ Yes _____ If yes, please describe. _____

_____

Signature of Parent/Guardian _____ **Date** _____

B. Physical Examination (This examination must be completed and signed by a licensed physician or a certified nurse practitioner.)

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: _____

_____

Name of authorized examiner/title (please print) _____

Phone number _____ **Date of examination** _____

Signature of authorized examiner _____

NOTE: Please attach a signed, up-to-date copy of the child's immunization record.