

Children's Medical Report

Name of Child _____ Birthdate _____

Name of Parent or Guardian _____

Address of Parent or Guardian _____

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 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 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 _____ Skin _____

Neurological System _____ TB 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)

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Name of Child _____ Date of Birth _____

PART III - IMMUNIZATION HISTORY:

The child care operator or health official must enter the date immunization was received in the spaces below or attach a copy of the child's immunization record. G.S. 130A-155(b) requires all child care facilities to have this information on file.

Enter the date of each dose as follows: Month/Day/Year:

VACCINE	#1	#2	#3	#4	#5
*DTP/DT (circle which)					
*Polio					
**Hib					
***Hepatitis B					
*MMR (combined doses)					
Other					

*Required by State law.

**Required by State law for children born on or after 10/1/88.

***Required by State law for children born on or after 7/1/94.

HOLY TRINITY GREEK ORTHODOX PRESCHOOL

MEDICAL RELEASE

We/I hereby give authorization and consent for the rendering to our/my child, _____, by a licensed physician or physicians, such medical services and treatment as may become necessary or advisable during the time my child is in the care of Holy Trinity Greek Orthodox Preschool, regardless of whether such treatment or services become necessary by reason of an emergency, unanticipated conditions, or otherwise. Such consent and authorization shall include the cooperation and assistance of any qualified medical personnel working under the supervision of licensed physicians.

We/I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment of our/my child's condition.

We/I hereby acknowledge that we are (I am) responsible for all reasonable charges in connection with care and treatment rendered.

We/I hereby give authorization for the use of 911 medical services for immediate treatment and transportation in emergency situations.

In case of emergency, we/I would like for our/my child to be cared for at _____ hospital in Charlotte, North Carolina.

Signed _____ Date _____

Signed _____ Date _____

This form must be signed by both parents/guardians.
In the case of divorce, the parent with custody of the minor child must sign.