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 # _____

(Continued on Back)

Office Address
(may use address stamp)

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