

**White Memorial Weekday School  
Health Report and Medical Examination**

Name of Child \_\_\_\_\_

Name of Parent(s) or Guardian(s) \_\_\_\_\_

A. Medical History (may be completed by parent)

1. Does child have allergies? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe.

2. Is child currently under a doctor's care (other than well care)? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, for what reason?

3. Any previous hospitalizations or operations? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, when and for what reason?

4. Any history of significant diseases, injuries, or recurrent illnesses? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe.

5. Does child have any physical disabilities? Yes \_\_\_\_\_ No \_\_\_\_\_

emotional disabilities? Yes \_\_\_\_\_ No \_\_\_\_\_

cognitive disabilities? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please describe.

**Signature of Parent or Guardian**

\_\_\_\_\_

**Date**

\_\_\_\_\_

**Please have doctor complete medical examination on back.**

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 another state), or a certified nurse practitioner.

Height \_\_\_\_\_ Percentile \_\_\_\_\_

Weight \_\_\_\_\_ Percentile \_\_\_\_\_

Head \_\_\_\_\_ Eyes \_\_\_\_\_ Ears \_\_\_\_\_ Nose \_\_\_\_\_ Teeth \_\_\_\_\_

Throat \_\_\_\_\_ Neck \_\_\_\_\_ Heart \_\_\_\_\_ Chest \_\_\_\_\_

Abd/GU \_\_\_\_\_ Ext \_\_\_\_\_ Neurological System \_\_\_\_\_ Skin \_\_\_\_\_

Vision \_\_\_\_\_ Hearing \_\_\_\_\_

Results of Tuberculin Test, if given: Type \_\_\_\_\_ Date \_\_\_\_\_  
Normal \_\_\_\_\_ Abnormal \_\_\_\_\_ Follow Up \_\_\_\_\_

Developmental Evaluation: Delayed \_\_\_\_\_ Age Appropriate \_\_\_\_\_  
If delayed, note significance and special care needed:

Should activities be limited: Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please explain.

Are immunizations current? Yes \_\_\_\_\_ No \_\_\_\_\_

**Please attach current immunization record.**

Any other recommendations?

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

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

Phone number \_\_\_\_\_