Dilworth UMC Weekday School Child's Medical Report

Bottom half of form to be completed by Pediatrician

Name of Child: ____ Birth Date: ___________________________

Name of Parent or Guardian: ____

Address: ____

A. Medical History (May be completed by Parent)

1. Is your child allergic to anything? No _____ Yes _____ If yes, what? ___________________________________

   ____

2. Does your child currently have any medical issues of which we should be aware? _________________________

   ____

3. Is your child on any continuous medication? No _____ Yes _____ If yes, what? ___________________________

   ____

4. Any previous hospitalizations or operations? No _____ Yes _____ If yes, what? ___________________________

   ____

5. Any history of significant previous disease or recurrent illness? No _____ Yes _____

   Diabetes _____ Convulsions _____ Heart Trouble _____ Other? ____

6. Does your child have any physical disabilities? No _____ Yes _____ If yes, please describe __________________

   ____

7. Any mental disabilities? No _____ Yes _____ If yes, please describe _______________________________________

   ____

B. Physical Examination: This examination must be filled out by a licensed physician, a certified nurse practitioner, or a public health nurse meeting DEHNR standards for EPSDT program. The date for this examination **may not be more than one year old.**

Height ______% Weight ______% Head ______ Eyes ______ Ears ______ Nose ______ Throat ______ Neck ______

Heart ______ Chest ______ Abd/GU ______ Ext ______ Neurological System ______ Skin ______

Should activities be limited? ____

Any other recommendations? ____

Signature of Authorized Examiner/Title ____

Date of Exam ____________________ Phone __________________ Office Address ______________________________

****Please return with a copy of your child's immunization record****