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 _____