Children's Medical Report

Name of Child: ________________________________ Age: ____ Date of Birth:____________________

Name of Parent(s): ____

Address: ____

Medical History ***(to be completed by parents/guardian)***

1. Previous Hospitalizations? Yes____ No____ If yes, explain: ____

   ____

2. Allergies? Yes____ No____ If yes, what? ____

   ____

   What is the allergic reaction? ____

   Treatment? ____

3. Any operations? Yes____ No____ If yes, please describe: ____

   ____

4. Any physical handicaps? Yes____ No____ If yes, please describe: ___________________________________

   ____

5. Is child under the care of a physician? Yes____ No____ If yes, for what reason? _______________________

   ____

History of: (check all that apply)

___asthma ___bleeding problems ___bone/muscle problems ___bowel problems ___cancer ___attention/learning __seizures ___Cystic Fibrosis ___Cerebral Palsy ___dental problems ___diabetes ___emotional/behavioral ___ear infections ___heart problems ___hearing problems ___meningitis ___sickle cell anemia ___vision ___skin problems ___speech problems ___stomach aches ___urinary/bladder ___other (explain): ___________________________

Parent/Guardian Signature: ____

Physical Examination **<u>(MUST be completed by examining physician)</u>** **(check if no problems)**

Date of Exam________________ Weight__________ Height___________ Blood Pressure _____________ Hear_________
Chest_________ Throat_________ Neck_________ Abdomen_________ GU___________ Ext._________ Neuro__________
Teeth__________ Skin__________ Head____________ Eyes_________ Ears _________

Should activities be limited? ______ Recommendations: ____

Physician's Signature: ______________________________________

Office Address or Office Stamp:

Date signed: _______________________