Medical Report *(to be completed by licensed physician)*

Child's Name: _____ Date of Birth: _____

Parent's Statement: I give my permission for the health practitioner to complete the following form. I understand it is for confidential use in meeting my child's health and educational needs at Kiddie Academy.

Parent/Guardian Signature_____ **Date**_____

Physical Examination *(This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the NC Board of Medical Examiners or a comparable board from bordering states, a certified nurse practitioner, or a public health nurse meeting DHHS standards for EPSDT program.*

Height _____% Weight _____% Neurological System _____

Head _____ Eyes _____ Ears _____ Nose _____ Teeth _____

Throat _____ Neck _____ Heart _____ Chest _____ Abd/GU _____

Ext _____ Skin _____ Vision _____ Hearing _____

Date of most recent tuberculin test: ____/____/____ Type _____ Result: ____Positive ____Negative ____ Follow-up

Date of last tetanus shot: ____/____/____

Developmental evaluation: Delayed _____ Age appropriate _____
If delay, note significance and special care needed: _____

This child has the following which may significantly affect his / her child care or educational experience:

			COMMENTS:
• Vision problem	☐Yes	☐No	_____
• Hearing problem	☐Yes	☐No	_____
• Speech or language problem	☐Yes	☐No	_____
• Other physical illness or impairment	☐Yes	☐No	_____
• Mental, emotional or behavior problems	☐Yes	☐No	_____
• Developmental delays	☐Yes	☐No	_____
• Allergies	☐Yes	☐No	_____

Significant physical findings, comments and recommendations: _____

This child has a health condition which may require care or emergency action while at child care / school. ☐Yes ☐No
Please specify (e.g., seizures, bee sting allergy, diabetes, etc.): _____
Recommendations: _____

This child has / is a know carrier of a communicable disease which should prevent his / her admission to a child care facility or school. ☐Yes ☐No
If YES, please specify: _____

This child requires a modified diet and / or special feeding procedures. ☐Yes ☐No
If YES, please specify: _____

Does this child have any limitations that would effect full participation at the academy? ☐Yes ☐No
If YES, please specify: _____

Does the child's physical activity need to be restricted? ☐Yes ☐No
If YES, please specify: _____

Does this child require any specialized treatment? ☐Yes ☐No
If YES, please specify: _____

Does this child require any adaptive equipment (e.g., braces, crutches, etc.)? ☐Yes ☐No
If YES, please specify: _____

Additional comments / other recommendations: _____

Date of Examination _____ **Signature of authorized examiner / title** _____ **Phone #** _____