CJP Children's Medical Report

Name of Child: _____ Birthdate: _____

Name of Parent/Guardian: _____

Address of Parent/Guardian: _____

A. Medical History (To be completed & signed by parent)

1. Is child allergic to anything? No___ Yes___ If yes describe in detail: _____

   _____

   (If yes is checked, parents will need to fill out an Allergy Action Plan)

2. Is child currently under a doctor's care? No____ Yes____ If yes, for what reason? _____

   _____

3. Is child on any continuous medication? No____ Yes____ If yes, what? _____

   _____

4. Any previous hospitalizations or operations? No ____ Yes _____ If yes, when and for what? _____

   _____

5. Any history of significant previous diseases or recurrent illness? No___ Yes___; Diabetes? No ____ Yes___;

   Convulsions? No___ Yes___; Heart trouble? No___ Yes___. If others, what? _____

6. Does child have any physical disabilities? No ___ Yes___ If yes, please describe: _____

   _____

B. Physical examination: This examination must be completed and signed by a licensed physician, an 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____% Head____ Eyes____ Ears____ Nose____ Teeth____ Throat___ Neck___ Heart___

Chest___ ABD/GU ___ Ext___ Neurological System _____ Skin_____

Results of TB test, if given: Type: _____ Date: _____ Normal: _____ Abnormal: _____

Should activities be limited? No_____ Yes_____ If yes, explain: _____

_____

Any other recommendations: _____

Is child up to date on all of his/her immunizations? Yes___ No____ If no, please explain: _____

_____

Date of Examination: ____/_____/_____

Signature & Title of authorized examiner _____

Phone number _____

Completed medical report can be faxed to Charlotte Jewish Preschool at 704-944-6898