MEDICAL STATEMENT

Aldersgate Week Day School

Child's Name: _____ Birth Date: _____
Name of Parent or Guardian: _____
Address: _____ State: _____ Zip: _____

A. Medical History (May be completed by parent):

1. Is child allergic to anything? Yes_____ No_____ If so, what?' _____
_____
2. Is child currently under a doctor's care? Yes _____ No _____ If yes, for what reason? _____
_____
3. Is the child on any continuous medication? Yes_____ No_____ If so, what? _____
_____
4. Any previous hospitalizations or operations? Yes_____ No_____ If so, when and for what? _____
_____
5. Any history or significant previous diseases or recurrent illness? Yes _____ No _____;
Diabetes Yes _____ No _____; convulsions Yes _____ No _____; heart trouble Yes _____ No _____;
If others, what/when? _____
6. Does the child have any physical disabilities? Yes _____ No _____ If yes, please describe? _____
_____
Any mental disabilities? Yes _____ No _____ If yes, please describe: _____
_____

Signature of Parent or Guardian _____

B. 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, a certified nurse practitioner, or public health nurse. Height_____% Weight_____%

Head _____ Eyes _____ Ears _____ Nose _____ Teeth _____ Throat _____
Neck _____ Heart _____ Chest _____ Abd/GU _____ Ext _____
Neurological System _____ Skin _____

Results of Tuberculin Test, if given: Type_____ Date: _____
Normal _____ Abnormal _____
Should activities be limited? Yes _____ No _____ If yes, explain: _____
_____
Any other recommendations? _____
_____

Signature of authorized examiner/title: _____

Date of examination _____ **Phone #** _____

You may attach a printed immunization record from the Dr's office