MYERS PARK PRESBYTERIAN CHURCH
Weekday School

Children's Medical Report

Name of Child _____ Date of Birth _____

A. Medical History (To be completed by parent or guardian for all WDS students)

1. Is the child up to date with all age level immunizations? ☐ Yes ☐ No – Please contact the WDS Office as soon as possible. **An updated immunization record is required for enrollment each year and must be submitted with this form.**

2. Is the child allergic to anything? ☐ No ☐ Yes - If yes, what? _____

If yes, is an allergy care plan on file or attached? ☐ No ☐ Yes

3. Is the child currently under a doctor's care? ☐ No ☐ Yes

If yes, for what reason? _____

4. Is the child on any continuous medication? ☐ No ☐ Yes - If yes, what? _____

5. Any previous hospitalizations or operations? ☐ No ☐ Yes

If yes, when and for what? _____

6. Any history of significant previous diseases or recurrent illnesses? ☐ No ☐ Yes; Diabetes ☐ No ☐ Yes; Convulsions ☐ No ☐ Yes; Heart trouble ☐ No ☐ Yes; Asthma ☐ No ☐ Yes

If others, what/when? _____

7. Does the child have any physical disabilities? ☐ No ☐ Yes

If yes, please describe: _____

8. Does the child have any mental disabilities? ☐ No ☐ Yes

If yes, please describe: _____

9. Is the child currently receiving therapy (speech, OT, PT, play therapy, etc.)? ☐ No ☐ Yes

If yes, please describe: _____

Signature of Parent/Guardian _____ **Date**_____

- **RETURNING Weekday School students - Stop here, and attach a copy of the current immunization record. Age level immunizations must be up to date. Page 2 is only needed for NEW students.**
- **NEW Weekday School students – Continue to page 2.**

- **NEW Weekday School students - Please have your physician complete Part B on page 2 and attach a copy of the current immunization record. Age level immunizations must be up to date.**

Name of Child _____ Date of Birth _____

B. New WDS Student Physical Examination: This examination must be completed and signed by a licensed physician, his/her authorized agent currently approved by the N. C. 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_____

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? ☐ No ☐ Yes

If yes, please explain: _____

_____

Any other recommendations: _____

Please attach a current immunization record. Age level immunizations must be up to date.

Date of Examination _____

Signature of Authorized Examiner/Title _____

Phone #_____