

BEREAN BAPTIST ACADEMY

518 Glensford Drive, Fayetteville, NC 28314

910.868.2511 Fax: 910.868.1550

www.bbafnc.org

Children's Medical Report (K3-K4)

Child's Name: _____ Birthdate: _____

Parent or Guardian: _____

Address: _____

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

1. Is child allergic to anything? No _____ Yes _____ If yes, what? _____

2. Is child currently under a doctor's care? No _____ Yes _____ If yes, why? _____

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 disease or recurrent illness? No _____ Yes _____
Diabetes No _____ Yes _____ Convulsions No _____ Yes _____ Heart Trouble No _____ Yes _____
If others, what/when? _____

6. Does the child have any physical disabilities? No _____ Yes _____ If yes, please describe. _____

Any mental disabilities? No _____ Yes _____ If yes, please describe. _____

Signature of Parent or Guardian: _____ Date: _____

B. Physical Examination: This examination must be completed and signed by a licensed physician, his 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 nurse meeting DEHNR standards for EPSDT program.

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? No _____ Yes _____ If yes, explain. _____

Any other recommendations: _____

Signature of Authorized Examiner/Title _____ Date _____

Office Address _____ Phone _____

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Immunization History

Name: _____ Date of Birth: _____

The child care operator or health official must enter the date immunization was received in the space below or attach a copy of the immunization record. G.S. 130A-155(b) requires all child care facilities to have this information on file.

Enter Date of Each Dose – Month/Day/Year

Vaccine	#1	#2	#3	#4	#5
DTP/DT* (Please circle one.)					
Polio*					
Hib**					
Hepatitis B***					
MMR* (Combined Doses.)					
Chicken Pox****					
Other					
Other					

*Required by State law.

**Required by State law for children born on or after 10/1/1988.

***Required by State law for children born on or after 7/1/1994.

****Required by State law for children born on or after 4/1/2001.