Renaissance
Classical Christian Academy

Children's Medical Report

Student's Name: _____

Date of Birth: _____ Grade: _____

Address: _____

Name of Parent/Guardian : _____

A. Medical History (may be completed by parent)

1. Is child allergic to anything? No_____ Yes_____
   If yes, describe - _____
   _____
   _____

2. Is child currently under a doctor's care? No_____ Yes_____
   If yes, describe - _____
   _____
   _____

3. Is child on any regular medication? No_____ Yes_____
   If yes, describe - _____
   _____
   _____

4. Any previous hospitalizations/surgery? No_____ Yes_____
   If yes, describe - _____
   _____
   _____

5. Any history of significant previous diseases (chronic or acute) or recurrent illness? No_____ Yes_____
   If yes, describe - _____
   _____
   _____

6. Does the child have any physical disabilities?No_____Yes_____
   If yes, describe - _____
   _____
   _____

7. Does the child have any mental disabilities? No_____ Yes_____
   If yes, describe - _____
   _____
   _____

_____ _____

Signature of Parent or Guardian ***Date***

Renaissance Classical Christian Academy
6427 Cliffdale Rd. Fayetteville, NC 28314 / Telephone: (910) 221-0400 / Fax: (910) 864-5476

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 of bordering states), a certified nurse practitioner, or a public health nurse meeting DEHNR standards for EPSDT program.

Height _____ Weight _____

Head _____ Teeth _____ Chest_____

Eyes _____ Throat_____ Abd/GU_____

Ears _____ Neck_____ Ext_____

Nose _____ Heart_____

Neurological System _____

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 of Exam***

_____
Telephone Number