



## Montessori Learning Community

WEST: 1 School Rd • Asheville, NC 28806 • (828) 259-9880

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www.mlcasheville.org

# Children's Medical Report

**An Immunization Record or Letter of Medical or Religious Exemption needs to accompany this Report**

Name of Child: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Name(s) of Caregivers: \_\_\_\_\_

Address(es) Caregivers: \_\_\_\_\_

### A. Medical History

*(to be completed by Parent or Physician)*

*Please answer yes or no. If answer is yes, please explain*

Previous hospitalization? \_\_\_\_\_

Is child allergic to anything? \_\_\_\_\_

Any previous diseases or illness? \_\_\_\_\_

Any operations? \_\_\_\_\_

Any history of convulsions? \_\_\_\_\_

Any history of diabetes in the family? \_\_\_\_\_

Any history of heart trouble? \_\_\_\_\_

Is child currently under care of a doctor? If yes, for what reason?

Parent or Guardian Signature \_\_\_\_\_

### B. Physical Examination

*(This section is to be completed and signed by a licensed physician or professional)*

<i>Weight</i>		<i>Abdomen</i>		<i>Eyes</i>
<i>Height</i>		<i>GU</i>		<i>Ears</i>
<i>Heart</i>		<i>Ext.</i>		
<i>Chest</i>		<i>Teeth</i>		
<i>Throat</i>		<i>Skin</i>		
<i>Neck</i>		<i>Head</i>		

T.B. \_\_\_\_\_ Neurological System \_\_\_\_\_

Should activities be limited? \_\_\_\_\_

Additional Recommendations? \_\_\_\_\_

**Signature of Physician:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Office Address \_\_\_\_\_ Phone \_\_\_\_\_