

# Medical Report

## STUDENT'S NAME

\_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Mother's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_ Cell \_\_\_\_\_

Father's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_ Cell \_\_\_\_\_

Emergency contact if unable to reach parents \_\_\_\_\_

Relationship \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Insurance Carrier \_\_\_\_\_ Insurance Phone \_\_\_\_\_ Insurance ID# \_\_\_\_\_

## GENERAL MEDICAL HISTORY

All medications and medical supplies (ie. Inhalers and diabetic supplies) must be kept in the main school office for K3 through 4th grade students and in the middle school office for 5th—8th grade students. Parents of students with Life Threatening Allergies will provide MRCA with a completed Mitchell Road Christian Academy Allergy Action Plan and Life Threatening Allergy Parent Agreement Page with the required number of Epi-Pens as indicated on the Life Threatening Allergy Parent Agreement Page. The Epi-Pens will be placed in the locations indicated on this agreement page.

Please indicate any medical conditions of which school personnel should be aware (e.g. ADD, ADHD, asthma, seizures) \_\_\_\_\_

Please list any allergies of which the school should be aware \_\_\_\_\_

Does your child take any medication regularly?  Yes  No If yes, please list medication, time medication is taken and specific instructions for use \_\_\_\_\_

Does your child have any known handicaps, mental or physical, that would limit his/her participation in our educational program?

Yes  No Explain: \_\_\_\_\_

## PAST ILLNESS OR PROBLEMS

Diabetes  Convulsions  Ear Infections  Hearing Loss  Attention Problems  Asthma  Seizures

## IMMUNIZATIONS

Please attach a current copy of your child's South Carolina Certificate of Immunization DHEC Form 1148 OR South Carolina Certificate of Religious Exemption (From Immunization) DHEC Form 1126.

## EMERGENCY CARE

I give permission to the administration of Mitchell Road Christian Academy to obtain emergency medical care in the most expedient manner at any licensed and qualified medical facility if I cannot be reached immediately to give my direction for care by my child's own physician.  Yes  No

PARENT SIGNATURE \_\_\_\_\_ Date \_\_\_\_\_

## PHYSICIAN EXAMINATION:

ITEM	WNL	ABN	ITEM	WNL	ABN
Head/Eyes			Ears/Throat/Neck		
Nodes			Liver/Spleen		
Skin			Heart		
Extmt			Lungs		
Genital			Abd		
Neurol					

Date: ___/___/20__	Ht: _____	Wt: _____
Lab: Hgb: _____	Urine: _____	
Hearing: Normal _____	Abnormal _____	
Vision: Normal _____	Abnormal _____	

## RECOMMENDATIONS OR RESTRICTIONS

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Name (Print) \_\_\_\_\_ Physician Phone \_\_\_\_\_