

MEDICAL REPORT

Student Name: _____ Birthdate: _____
Last First Middle

Mother's Name: _____ Daytime Phone: _____ Mobile: _____

Father's Name: _____ Daytime Phone: _____ Mobile: _____

Emergency contact if unable to reach parents: _____

Name of Physician: _____ Phone: _____

Past Illness or Problems

Diabetes _____
 Convulsions _____
 Ear Infections _____
 Hearing Loss _____
 Attention Problems _____
 Asthma _____

Allergies

Medications _____
 Other _____

Current Medications

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

Medication Administration

My child can be given the following Non-prescription Medication: (please check all that apply)

Tylenol (acetaminophen) Benadryl Liquid Benadryl Tablets Cough Drops
 Mylanta

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			Liver/Spleen		
Nodes			Skin		
Heart			Extmt		
Lungs			Genital		
Abd			Neurol		

Date ____/____/200__ Ht ____ Wt ____
 Lab: Hgb _____ Urine _____

Hearing: Normal ____ Abnormal ____
 Vision: Normal ____ Abnormal ____

Recommendations or Restrictions: _____

Physician Signature: _____