Aviation AllStars Mother's Morning Out

~SOAR Academy~

Medical Forms

Child's Name: _____
(first) (middle) (last)

Birthdate: _____/_____/_____ Male ___ Female ____

Immunization Records

Child's Name: _____Date of Birth: _____

Enter the date an immunization was received in the space below or attach a copy of the immunization record.

Enter the date of each dose—Month/Date/Year

VACCINE	1	2	3	4	5
*DTP/DT circle which					
*Polio					
*Hb					
*Hepatitis B					
*MMR combined doses					

*Chicken Pox				
Other				
Other				
*Required by state law.				
Records Updated By: include printed name and signature			Date Entered:	

School Year: _____

Child's Name: _____ (first) (middle) (last)

Birthdate: _____/_____/_____ Male ___ Female ___

Child Health Assessment

Part A. Medical History (Parent may complete this section.) Please write clearly.
Does your child have any known allergies or sensitivities to: (Check all that apply)

Medications	Yes/No
Foods	Yes/No
Other	Yes/No

Illnesses or Medical Conditions

Does your child have any of the following?:

Asthma	Yes/No
Diabetes	Yes/No
Seizures	Yes/No
Heart Problems Hearing Impairment	Yes/No
Visual Impairment	Yes/No
Developmental Delays	Yes/No
Physical Impairment	Yes/No
Behavioral or Emotional Problems	Yes/No

Other: _____

Please describe any of the above Yes responses, and list any additional health information or special instructions you feel we need to be aware of:

_____
_____
_____

List any regular medications your child takes:

_____

Signature of Parent or Guardian _____
Date_____

Part B. Physical Examination: This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the NC Board of Medical Examiners, or certified nurse practitioner.

Height _____% Weight _____%

Head_____Eyes_____Ears_____Nose_____Teeth_____Throat____ ____ Neck_____Heart_____Chest_____Abd/GU_____Ext

Neurological
System_____Skin_____Vision_____Hearing__ _____ Results of Tuberculin Test, if given:
Type_____Date_____Normal___Abnormal___Followup_____ Developmental Evaluation: Delayed_____ Age Appropriate_____

If delay, note significance and special care needed:
_____
_____

Should activities be limited? Yes_____ No _____ If yes, explain:
_____

Any other recommendations:
_____

Date of Examination: _____

Signature of authorized examiner/title
_____Phone_____