

Christian Family Services, Inc.

MEDICAL REPORT ON CHILD

Child's Name _____ DOB _____

Parents' Names _____

Date of Examination _____

Age _____ Gender _____ Height _____ Weight _____

Are immunizations current? Yes ___ No ___ If not, what is the immunization plan?

Describe the status of: Vision _____ Hearing _____ Speech _____

Describe past medical history, including birth and infancy, surgeries, traumas, hospitalizations, serious diseases and disorders. Include treatment and prognosis.

Describe any communicable disease, including HIV/AIDS, Tuberculosis, and Hepatitis B, the patient has. Include treatment and prognosis.

Describe any mental health or chemical dependency problems the patient has. Include treatment and prognosis.

Describe any physical limitations the patient has. Include treatment and prognosis.

Describe the findings of the patient's examination.

Physician's remarks _____

Physician's Signature

Printed Name

Date

Please send this form to:

Christian Family Services, Inc.

PO Box 36426

Rock Hill, SC 29732

Phone: (803) 328-2229