

**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