

MEDICAL REPORT OF CHILD IN KIDS OF THE KINGDOM PROGRAM

To be completed by Physician, Physician's Assistant or Nurse Practitioner

Name _____ Date of Birth _____ Date of Exam _____

IMMUNIZATIONS

If one or more of the required medical immunizations is deemed detrimental to this child's health, attach certificate specifying which immunization(s) and complete and sign medical exemption statement on back of form.

	Include All Dates				Other Immunizations		
	1st	2 nd	3rd	Booster	Booster	Type	Date
DPT							
ORAL POLIO							
Hib (conjugate Preferred)							
Hepatitis B				4th			
MMR							

TESTS

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If positive, attach physician's statement documenting treatment and follow-up	Attach statement of lead screening														

HEALTH SPECIFICS	Comments
Yes No Are there allergies? (Specify)	
Yes No Is medication regularly taken? (specify drug and condition)	
Yes No Is a special diet required? (specify diet and condition)	
Yes No Are there any hearing, visual or dental conditions requiring special attention?	

SUMMARY OF PHYSICAL EXAM (including special recommendations to Kids of the Kingdom Provider)

On the basis of my findings as indicated above and on my knowledge of the above named child, I find that (s)he is free from contagious and communicable disease () Yes () No and is able to participate in Kids of the Kingdom Program () Yes () No

Signature of Examiner	Address
Name (please print)	City, State, Zip
Title	Phone
	Date