CHILDREN'S MEDICAL REPORT

Name of Child _____ Birthdate _____

Name of Parent or Guardian _____

Address of Parent of Guardian _____

A. Medical History (May be completed by parent)

1. Is child allergic to anything? No_____ Yes_____ If yes, what? _____

   _____

2. Is child currently under a doctor's care? No_____ Yes_____ If yes, for what reason?_____

   _____

3. Is the child on any continuous medication? No_____ Yes_____ If yes, what?_____

   _____

4. Any previous hospitalizations or operations? No_____ Yes_____ If yes, when and for what?_____

   _____

5. Any history of significant previous diseases or recurrent illness? No_____ Yes_____ ;
   diabetes No_____ Yes_____ ; convulsions No_____ Yes_____ ; heart trouble No_____ Yes_____ ;
   If others what/when?_____

   _____

6. Does the child have any physical disabilities: No_____ Yes_____ If yes, please describe: _____

   _____

   Any mental disabilities? No_____ Yes_____ If yes, please describe: _____

Signature of Parent or Guardian _____ Date _____

B. Physical Examination: This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the N. C. Board of Medical Examiners (or a comparable board from bordering states), a certified nurse practitioner, or a public health nurse meeting DEHNR standards for EPSDT program.

Height _____% Weight _____%

Head_____ Eyes_____ Ears_____ Nose_____ Teeth_____

Throat_____ Neck_____ Heart_____ Chest_____ Abd/GU_____

Ext_____ Neurological System_____ Skin_____

Results of Tuberculin Test, if given: Type_____ Date_____ Normal_____ Abnormal_____

Should activities be limited? No_____ Yes_____ If yes, explain: _____

Any other recommendations:_____

_____

_____ Date of Examination: _____

Signature of authorized examiner/title _____ Phone # _____

CHILDREN'S IMMUNIZATION HISTORY

Name of Child _____ Birthdate _____

Enter the date an immunization was received in the space below or attach a copy of the immunization record. G.S. 130A-155(b) requires all child care facilities to have this information on file.

Enter date of each dose . Month/Day/Year

VACCINE	#1	#2	#3	#4	#5
*DTP/DT (circle which)					
*Polio					
**Hib					
***Hepatitis B					
*MMR (combined doses)					
OTHER					

*** Required by State Law.**
**** Required by State Law for children born on or after 10/1/88**
***** Required by State Law for children born on or after 7/1/94**

Records Updated By:	Date Updated: