

CHILDREN'S MEDICAL REPORT

Name of Child _____ Age _____ Birthdate _____
 Name of Parent or Guardian _____
 Address of Parent or Guardian _____
 (Street) (City) (State)

A. MEDICAL HISTORY (May be completed by parent)

1. Previous hospitalization: Yes _____ No _____ If so, why? _____
2. Is child allergic to anything: Yes _____ No _____ If so, what? _____
3. Any previous diseases or illness: Yes _____ No _____ If so, what? _____
4. Any questions: Yes _____ No _____ If so, what? _____
5. Any physical handicaps: Yes _____ No _____ If so, please describe: _____
6. Is child under care of a doctor: Yes _____ No _____ If so, for what reason? _____
7. Any history of mental retardation: Yes _____ No _____
8. Any history of convulsions: Yes _____ No _____
9. Any history of diabetes in family: Yes _____ No _____
10. Any history of heart trouble: Yes _____ No _____

(Parent's Signature)

B. PHYSICAL EXAMINATION: This examination must be completed and signed by a licensed physician or his or her authorized agent who is currently approved by the N. C. Board of Medical Examiners.

Weight _____ Height _____ Heart _____
 Chest _____ Throat _____ Neck _____ Abdomen _____
 GU _____ Ext. _____
 Neurological System _____
 Teeth _____ Skin _____ Head _____ Eyes _____ Ears _____
 Results of Tuberculin Test, If given _____
 (Type) (Results)
 Should activities be limited? _____
 Recommendations: _____

 (Signature of physician or authorized agent who is currently approved by the N.C. Board of Medical Examiners) Date of Examination _____

 Office Address Telephone Number

IMMUNIZATION HISTORY: The day care operator must enter the date each immunization was received. G.S. 130-90 (B) requires all day care facilities to have this information on file.

DATE VACCINE	DATE	DATE	DATE	DATE
*DTP				
TD or Tetanus				
*Polio, oral				
*Rubeola (measles)				
*Mumps				
*Rubella (German measles)				
*HIB				

*Required by State law. G.S. 130-87(b) requires measles vaccine to be given on or after the first birthday.