## **Children's Medical Report**

Name	of Child Date of Birth				
Name	of Parent(s) / Guardian(s)				
Addres	ss of Parent(s) / Guardian(s)				
A. ME	DICAL 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 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.	Has child had chicken pox? No Yes				
7.	Does child have any physical disabilities? No Yes If yes, please describe				
Ar	ny mental disabilities? No Yes If yes, please describe				
Sig	gnature of parent or guardian				
B. PH	YSICAL EXAMINATION				
Th	is examination must be completed and signed by a licensed physician, his/her authorized agent currently				

This examination must be completed and signed by a licensed physician, his/her 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 Head Throat Ext	Eyes Neck	Ears _ Heart		Teeth Abd/GU		
Results of Tuberculin Test if given: Type DateNormal Abnormal						
Should activities be limited? No Yes If yes, explain Any other recommendations:						
Signature of authorized examiner/title						
Date of Examinatio	n	Phone				

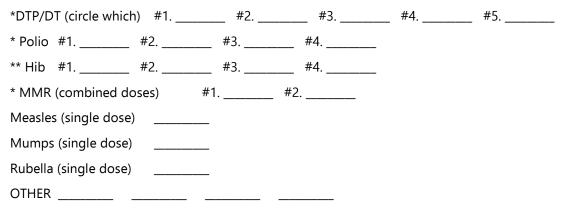
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C. IMMUNIZATIONS HISTORY: Fill in below or attach copy of the immunization record.

G.S. 130A-155(b) requires all day care facilities to have this information on file.

## Enter date of each dose - Month/Day/Year

## VACCINE



\* Required by State law.

\*\*Required by State law for children born on or after 10/01/91