

CHILD'S MEDICAL REPORT

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

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 operations? Yes _____ No _____ If so, what? _____
5. Any physical handicaps? Yes _____ No _____ If so, 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 truble? 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 NC Board of Medical Examiners.

Weight _____ Height _____ Heart _____
 Chest _____ Throat _____ Neck _____ 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 NC Board of Medical Examiners?)

(Date of Examination)

(Office Address)

(Telephone Number)

C. 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.

VACCINE	DATE	DATE	DATE	DATE
DPT				
Hib				
Hep B				
Polio, Oral				
MMR	Varicela			

(Enter medical clinic stamp in space)