## **Children's Medical Report**



of Parent(s)	or Guardian(s):	<del> </del>			
ess of Parent(	(s) or Guardian(s):				
Λ Medical Hi	story (May be completed	hy parent)			
	ergic to anything? No	,	If ves what?		
1. 10 orma am	orgio to arrytimig. Two	100	ii yoo, wiiat:		
2. Is child cu	rrently under a doctor'	s care? No _	Yes If yes	s, for what reas	son?
3. Is the child	d on any continuous m	nedication(s)?	No Yes	If yes, what?	
4. Any previo	ous hospitalizations or	operations?	No Yes	If yes, when a	nd for what?
5 Any histor	y of significant previou	is dispasals) c	or recurrent illness/es	s)? No '	Yes
_			·	,	
diabetes	s No;	Convuisions	NO, Tes,	nean trouble i	NO Yes
If others	, what/when?				
If others	, what/when?child have any physica				
If others					
If others  6. Does the o	child have any physica	al disabilities?	No Yes	If yes, please	describe:
If others  6. Does the o		al disabilities?	No Yes	If yes, please	describe:
If others  6. Does the o	child have any physica	al disabilities?	No Yes	If yes, please	describe:
If others 6. Does the officers Any ments	child have any physica al disabilities? No	al disabilities?  Yes I	No Yes f yes, please describ	If yes, please	describe:
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If others 6. Does the off Any menta Signature of  B. Physical E authorized age	Parent/Guardian:  Examination: This examination approved by the contraction and the contraction approved by the contraction approximation approximation approximation approximation approximation appr	nation must be of	f yes, please describe completed and signed by Medical Examiners (or	If yes, please  Date  y a licensed physical comparable books.	e:sician, his/her
If others 6. Does the off Any menta Signature of  B. Physical E authorized age	child have any physical disabilities? No  Parent/Guardian:	nation must be of	f yes, please describe completed and signed by Medical Examiners (or	If yes, please  Date  y a licensed physical comparable books.	e:sician, his/her
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If others 6. Does the off Any menta  Signature of  B. Physical E authorized age states), a certif  Height Head	Parent/Guardian:  Examination: This examination approved by the field nurse practitioner, or a weight	nation must be of the NC Board of a public health n	f yes, please describe  completed and signed by Medical Examiners (or lurse meeting DEHNR s	If yes, please  De:  Date  y a licensed physical comparable bootstandards for EPS	e:sician, his/her pard from bordering SDT program.
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If others 6. Does the of Any menta Any menta Signature of  B. Physical E authorized age states), a certif Height Head Throat Ext Ext Should activi	Parent/Guardian:  Examination: This examination approved by the field nurse practitioner, or a series with the content of the	nation must be of the NC Board of a public health new Heart Bystem Type Type Tes Type Type Tes Type Tes Type Type Type Type Type Type Type Type	f yes, please describe  completed and signed by Medical Examiners (or Jurse meeting DEHNR services and Chest	If yes, please  Date  y a licensed physical comparable bottandards for EPS  About Skin Normal	e: sician, his/her pard from bordering SDT program.  eth d/GU



## **Immunization History**

Name:	Birthdate:

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

<b>VACCINE</b>	#1	#2	#3	#4	#5
DTP/DT*					
(Circle Which)					
Polio*					
Hib**					
Hepatitis B***					
MMR*					
(Combined Doses)					
Varicella****					
OTHER					
OTHER					
OTHER					

Date Updated:	Records Updated By:

<sup>\*</sup> Required by State Law

\*\* Require by State Law for children born on or after October 1<sup>st</sup>, 1988.

\*\*\* Require by State Law for children born on or after July 1<sup>st</sup>, 1994.

\*\*\*\* Require by State Law for children born on or after April 1<sup>st</sup>, 2001.