



Child's Last Name, First Name: _____

| 1501 Queens Rd. | Charlotte, NC 28207 | 704.376.5208 | 704.376.0423 fax

Medical Form

Name of Child _____ DOB _____ School Year _____
Parent or Guardian _____ Primary Phone # _____
Address _____
Child's Physician _____ Physician's Phone _____
Physician's Address _____

A. Physical Examination: 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 _____ Weight _____
Head _____ Eyes _____ Ears _____ Nose _____ Teeth _____
Throat _____ Neck _____ Heart _____ Chest _____ Abd/GU _____
General Appearance: Good _____ Fair _____ Poor _____
Ext _____ Neurological System _____ Skin _____
Tuberculin Test Results, if given: Date _____ Type _____ Normal _____ Abnormal _____
Should activities be limited? No ___ Yes ___ If yes, explain: _____
Any other recommendations: _____

Immunization Record: Attach a copy of the immunization record. *G.S. 130A-155(b) requires all childcare facilities to have this information on file.*

Required Immunizations: DTP or DT (Diphtheria, Tetanus, Pertussis), Polio, MMR, Measles [Mumps, Rubella (combined doses)], Hib (Haemophilus influenza type B), Varicella (Chicken Pox), Other

Signature (authorized examiner/title) _____ Date of Examination _____

B. Medical History (May be completed by parent)

1. Allergies No ___ Yes ___ Please list: _____
2. Asthma No ___ Yes ___ List medications: _____
3. Diabetes No ___ Yes ___ List medications: _____
4. Chicken Pox No ___ Yes ___ Disease date: _____
5. Is the child on any continuous medication? No ___ Yes ___ If yes, what? _____
6. Any previous hospitalizations/surgeries? No ___ Yes ___ If yes, when and for what? _____
7. Any history of significant previous diseases or recurrent illness? No ___ Yes ___
If others, what/when? _____
8. Does the child have any physical disabilities? No ___ Yes ___ If yes, please describe: _____
9. Is child currently under a doctor's care? No ___ Yes ___ If yes, for what reason? _____
10. Any mental disabilities? No ___ Yes ___ If yes, please describe: _____

Signature of Parent or Guardian _____ Date _____