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

Child's Last Name, First Name:

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**_____