Revised 7/13/2015

CHILDREN'S HEALTH/MEDICAL REPORT

Name of Child ________________________________ Sex____ Date of Birth ____________ Place of Birth ___________________

Name of Parent/ Guardian ____

Address of Parent/ Guardian ____

HEALTH/MEDICAL HISTORY

Section A. *(May be completed by parent)*

Is the child allergic to anything (include reactions to drugs)? No ____ Yes _____
(If yes, the school may require an action plan from physician)
If yes, please describe____

Is the child currently under a doctor's care? No ____ Yes _____ (If yes, the school may require an action plan from physician)
Please describe reason: ____

Is the child on any continuous medication? No ____ Yes _____ If yes, please list type, dosage & purpose ________
____

Any previous hospitalizations or operations? No ____ Yes _____ If yes, please when & for what_________________
____

Any history of significant previous disease or recurrent illness: No ____ Yes _____
(circle all that apply) Diabetes Convulsions/ Seizures Heart trouble Asthma Gastrointestinal
If others, what/when? ____

Does the child have any physical disabilities?: No ____ Yes _____ If yes, please describe_______________________
____

Any mental disabilities?: No ____ Yes _____ If yes, please describe____
____

Signature of Parent or Guardian ________________________________ Date _____________

Section B. Physical Examination: This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the NC Board of Medical Examiners (or a comparable board from bordering states), a certified nurse practitioner, or a public nurse meeting DHHS standards for EPSDT program.

Height ________ Weight ________

Head_________ Eyes __________ Ears __________ Nose ___________ Teeth ___________Throat__________
Neck _________ Heart _________ Chest _________ Abd/GU _________ Ext __________
Neurological System________________ Skin _____________ Vision ___________ Hearing ___________
Results of Tuberculin Test, if given: Type _______ date _______ Normal _____ Abnormal ____ follow-up ______

Developmental Evaluation: delayed __________ age appropriate ____
If delay, note significance and special care needed: ____
____

Should activities be limited? No ____ Yes ____ If yes, please explain: ______________________________________
Any other recommendations: ____
____

Has this child been screened for lead at 12 & 24 months of age, or once before the age of 6? No___ Yes ___

Date of Examination _____________

Signature of authorized examiner/ title ________________________________ Phone # _______________

Print name : _____________________________________

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Name of Child : ____________________________________ Date of Birth : _________________________

Enter the date an immunization was received in the space below or attach a copy of the immunization record.
North Carolina law under General Statue G. S. 130A-155(b) requires all school and child care facilities to have this information on file.

Enter date of each dose (Month/ Day/ Year)

VACCINES Required by NC law	#1	#2	#3	#4	#5
DTaP (5 doses)					
POLIO (4 doses)					
HIB (3-4 doses)					
MMR (2 doses)					
Hepatitis B (3 doses)					
Varicella (1-2 doses)					
*PCV					
Other					
Other					

* Pneumococcal Conjugate Vaccine (PCV) is required for all children born on or after July 1, 2015. The # of doses required varies based on the age of child at child's first vaccine.

For adolescents entering 7th grade

VACCINE	#1
**Tdap (1 dose)	
Meningoccal Conjugate Vaccine (1 dose)	

**A dose of tetanus/diphtheria/pertussis vaccine is required for individuals entering the seventh grade on or by 12 years of age on or after July 1, 2015

______ MEDICAL EXEMPTION ATTACHED ______RELIGIOUS EXEMPTION ATTACHED

Exemptions from NC State Immunization Law require that a statement must be on file at school in student's permanent record. Exemptions must meet requirements of the law. Consult your local health department.

Physician must sign this form regardless if exemption letter is attached.