DCD 0108
12/99

Children's Medical Report

Name of Child: _____ Birthdate: _____

Name of Parent or Guardian: _____

Address of Parent or Guardian: _____

A. Medical History (May be completed by parent)

1. Is child allergic to anything? ☐ No ☐ Yes If yes, what? _____
2. Is child currently under a doctor's care? ☐ No ☐ Yes If yes, for what reason?
3. Is the child on any continuous medication? ☐ No ☐ Yes If yes, what?
4. Any previous hospitalizations or operations? ☐ No ☐ Yes If yes, when and for what?
5. Any history of significant previous diseases or recurrent illness? ☐ No ☐ Yes; diabetes ☐ No ☐ Yes; convulsions ☐ No ☐ Yes; heart trouble ☐ No ☐ Yes; asthma ☐ No ☐ Yes.

If others, what/when? _____

6. 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:** _____

B. Physical Examination: This examination must be completed and signed by a licensed physician, his 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 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 delayed, note significance and special care needed: _____

Should activities be limited? ☐ No ☐ Yes If yes, explain: _____

Any other recommendations: _____

_____

Date of Examination: _____

Signature of authorized examiner/title: _____ **Phone#:** _____

NOTICE OF IMMUNIZATION REQUIREMENTS FOR CHILDREN IN NORTHSIDE CHILD CARE & ACADEMY FOR EARLY LEARNING

Date: _____

Child's Name: _____ Birthdate: _____

By the first birthday a child should have had:

3 DTP (by 7 mos.)

3 HIB (by 7 mos.)

2 OPV (by 5 mos.)

3 HBV (given at 6 mos. To 19 mos.) if born after 7-1-94

1 Varicella (between 12 & 19 months) if born on or after 2/01/02

4 DTP (by 19 mos.)

4 HIB (by 16 mos.)

3 OPV (by 19 mos.)

1 MMR (after 12 mos. and before 16 mos.)

After 4th birthday and before entering school a child should have had:

5 DTP (one dose must have been given on or after the fourth birthday.)

4 OPV (one dose must have been given on or after the fourth birthday.)

2 MMR (1 by 16 mos. 2nd before entering school.)

NOTICE OF DELINQUENT IMMUNIZATION STATUS:

Based on your child's Certificate of Health record in their file, your child needs:

_____ DTP
_____ MMR
_____ Polio
_____ Varicella
_____ No record on file. A complete immunization record is needed with the date of each immunization given.

_____ Hepatits B
_____Other
_____ HIB*
Please have your doctor note if your child is on the **3 shot or 4 shot HIB series.*

If you have any questions, please call Lisa Stegall at 598-9665, ext. 2208.
Note: If your child has already received this/these immunization(s), you should, without delay, provide proof of this to the child Care Center.

Please have these forms returned to our office by: _____
For your convenience, these forms may be faxed to us at: (704) 602-2399.