

# Children's Medical Report

Name of Child _____	Birthdate _____
Name of Parent or Guardian _____	
Address of Parent of Guardian _____	
<p><b>Physical Examination:</b> 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 DEHNR standards for EPSDT program.</p>	
Height _____%    Weight _____%	
Head _____	Eyes _____ Ears _____ Nose _____ Teeth _____
Thrc _____	Neck _____ Heart _____ Chest _____ Abd/GU _____
Ext _____	Neurological System _____ Skin _____
Results of Tuberculin Test, if given: Type _____ date _____ Normal ___ Abnormal _____	
Should activities be limited? No ___ Yes ___ If yes, explain: _____	
Any other recommendations: _____	
_____	Date of Examination _____
Signature of authorized examiner/title _____ Phone # _____	

## Immunization History

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

**Enter date of each dose - Month/Day/Year**

VACCINE	#1	#2	#3	#4	#5
*DTP / DT (circle which)					
*Polio					
**Hib					
***Hepatitis B					
*MMR (combined doses)					
****Chicken Pox					
OTHER					
OTHER					

\*Required by State law.  
 \*\*Required by State law for children born on or after 10/1/88.  
 \*\*\*Required by State law for children born on or after 7/1/94.  
 \*\*\*\*Required by State law for children born on or after 4/1/01.

Records Updated by:	Date Updated:

Good Shepherd Preschool  
 Fax: 919/848-0254  
 Attention: Preschool Director