*As noted below, this form requires a medical provider's signature*PLEASE PRINT AND RETURN

DCD 0108 12/99

Children's Medical Report

ame of Child					Birthdate	
Name of Parent o	r Guardian					
Address of Paren	t of Guardian					
Medical Histor	y (May be comp	pleted by pare	ent)			
Is child allergic	to anything? No	o Yes	If yes, what	t?		
Is child currentl	y under a doctor	's care? No_	Yes I	f yes, for wh	nat reason?	
Is the child on a	ny continuous m	nedication? N	loYes	_ If yes, wh	nat?	
Any previous ho	ospitalizations o	r operations?	No Yes_	If yes, w	hen and for what?_	
convulsions No	Yes; he	eart trouble N	o Yes	_; asthma No	Yes; diabete	
Does the child h	ave any physica	al disabilities:	No Yes	If yes, p	please describe:	
ny mental disabil					D	ate
gnature of Pare 3. Physical Exar agent current states), a cert	nt or Guardian nination: This e ly approved by t ified nurse pract	examination mathe N. C. Boar	nust be comp rd of Medica ublic health	oleted and sig	gned by a licensed p (or a comparable bong DHHS standards	hysician, his autoard from borde
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Immunization History

	Enter	date of each dose	- Month/Day/Ye	ar	
VACCINE	#1	#2	#3	#4	#5
*DTP / DT (circle					
which) *Polio					
**Hib					
*Hepatitis B					
*MMR					
(combined doses)					
***Chicken Pox					
OTHER					
*Required by state lav	w, however the re		oster dose, #4, is te	mporarily suspend	led.
*Required by state lav **Required by state lav ***Required by State lav	w, however the re w for children bo				led.
*Required by state lav **Required by state lav ***Required by State lav	w, however the re w for children bo			mporarily suspend	led.
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*Required by state lav **Required by state lav ***Required by State lav	w, however the re w for children bo				led.
*Required by state law **Required by state law ***Required by State law	w, however the re w for children bo				led.
*Required by state lav **Required by state lav ***Required by State lav	w, however the re w for children bo				led.
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