



CHILDREN'S MEDICAL REPORT

(STATE REQUIRED FORM)

Name of Child _____ Birthdate _____

Name of Parent or Guardian _____

Address of Parent or Guardian _____

A. Medical History (May be completed by Parent)

- Is child allergic to anything? No _____
If Yes, what? _____
- Is child currently under a doctor's care? No _____
If Yes, for what reason? _____
- Is the child on any continuous medication? No _____
If Yes, what? _____
- Any previous hospitalizations or operations? No _____
If Yes, when and for what? _____
- 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? _____
- 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 NC Board of Medical Examiners (or a comparable board from bordering states), a certified nurse practitioner, or a public health nurse meeting the DHHS standards for EPSDT program.

Height _____ % Weight _____ %

Head _____ Eyes _____ Ears _____ Nose _____ Teeth _____ Throat _____ Vision _____

Neck _____ Heart _____ Chest _____ Abd/GU _____ Ext _____ Skin _____ Hearing _____

Neurological System _____

Results of Tuberculin Test, if given: Type _____ Date _____ Normal _____ Abnormal _____

Developmental Evaluation: Delayed _____ Age Appropriate: _____

If Delay, 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 # _____



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IMMUNIZATION HISTORY

G.S. 130A-155. SUBMISSION OF CERTIFICATE TO CHILD CARE FACILITY/G.S.130-A-154. CERTIFICATE OF IMMUNIZATION

(MUST BE UPDATED EACH YEAR ENROLLED AT WFCP)

Name: _____ Date of Birth: _____

The parent/guardian must submit a certificate of immunization on child's first day of attendance or within 30 calendar days from the first day of attendance. Child may not attend the facility until submitted.

Enter date of each dose - Month/Day/Year

VACCINE	Abbreviation	Trade Name	Combination Vaccines	#1 Date	#2 Date	#3 Date	#4 Date	#5 Date
Diphtheria, Tetanus, Pertussis (Circle Which)	DTap, DT, DTP	Infanix, Daptacel	Pediarix, Pentacel, Kinrix					
Polio	IPV, OPV	I POL	Pediarix, Pentacel, Kinrix					
Haemophilus Influenza, B	HIB	Act HIB, Pedvax HIB**	Pentacel					
Hepatitis B	HepB, HBV	Engerix-B, Recombivax HB	Pediarix					
Measles, Mumps, Rubella	MMR	MMR II	Proquad					
Varicella/Chicken Pox	Var	Varivax	Proquad					
Pneumococcal, Conjugate*	PCV, PCV-13, PPV-23	Pneumovax***						

* Required by State law for children born on or after 7/1/2015

** 3 shots of Pedvax HIB are equivalent to 4 HIB doses. 4 doses are required if a child receives more than one brand of Hib shots.

***Pneumovax is a different vaccine than Prevnar and may be seen in high risk children.

NOTE: Children beyond their 5th birthday are not required to receive Hib or PCV vaccines.

Vaccines Recommended by the Advisory Committee on Immunization Practices (ACIP) NOT Required

VACCINE	Abbreviation	Trade Name	Recommended Schedule	#1 Date	#2 Date	#3 Date	#4 Date	#5 Date
Rotavirus	RV, Rota	Roteteq Rotarix	Age 2 months, 4 months, 6 months					
Hepatitis A	Hep A	Haviris Vaqta	First Dose, 12-23 months; Second Dose within 6-18 months					
Influenza	Flu	Fluzone Fluarix FluLaval Fluviri FluMist Afluria	Annually after age 6 months					