CHILDREN'S HEALTH RECORD

Name of child _____Age _____Birthdate _____
Name of Parent/Guardian _____
Address of Parent/Guardian _____
(Street) (City) (State)
(Zip)

A. MEDICAL HISTORY (May be completed by parent)

1. Previous hospitalization: Yes ____ No _____If so, why?_____
2. Is the child allergic to anything? Yes_____No _____ If so, what?_____
3. Any previous disease or illness? Yes____ No _____ If so, what?
4. Any operations? Yes ___ No _____If so, what?
5. Any physical handicaps? Yes ____No _____ If so, please describe
6. Is child under care of a doctor? Yes ____No____ If so, for what reason?
7. Any history of mental retardation? Yes ____No
8. Any history of convulsions? Yes ___ No ____
9. Any history of diabetes in family? Yes ___ No _
10. Any history of heart trouble? Yes____ No ____

Parent's Signature

B. PHYSICAL EXAMINATION: This examination must be completed and SIGNED by a licensed physician or his/her authorized agent who is currently approved by the N.C. Board of Medical Examiners.

Weight_____ Height _____ Heart_____ Chest_____ Throat _

Neck Abdomen GU Ext.

Neurological System

Teeth_____ Skin _____ Head_____Eyes_____Ears

Results of Tuberculin Test, if given:_____
(Type) (Results)

Should activities be limited?

Recommendations

Signature of physician/authorized agent currently approved by the N.C. Board of Medical Examiners

Date of Examination

Office Address

Office Phone Number

* SEE BACK for IMMUNIZATION HISTORY *

C. IMMUNIZATION HISTORY:

VACCINE	DATE	DATE	DATE	DATE	DATE
*DTP					
Td					
* Polio, oral					
* Rubeola (measles)					
Mumps					
* Rubella (German measles)					
*HTO					

*** Required by State Law G.S.** 130-87(b) **requires measles vaccine to be given on or after the first birthday.**