This form must be on file with Kim Tasker within the first 30 calendar days of your child's attendance.

Children's Medical Report

Parent(s) and Pediatrician must fill in both sides completely. Once report is complete, it may be faxed to 704.887.3676 or emailed to ktasker@calvarycdc.com.

Name of Child_____Birthdate_____

Name of Parent or Guardian _____

Address of Parent or Guardian _____

A. Medical History (May be completed by parent/guardian)

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, _____

_____

4. Any previous hospitalizations or operations? No_____ Yes_____ If yes, when and what for?

_____

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/Guardian _____ **Date**_____

The portion below must be completed by the child's physician.

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 DEHNR 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_____

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

Any other recommendations: _____

_____

Developmental Evaluation: delayed _____ age appropriate _____

If delay, note significance and special care needed: _____

_____

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

_____

_____

Date of Examination _____

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

Immunization History

G.S. 130A-155. Submission of certificate to child care facility/G.S.130A-154. Certificate of immunization.

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.

Child's full name:	Date of birth:

Enter each date of each dose received (Month/Day/Year) or attach a copy of the immunization record.

Vaccine Type	Abbreviation	Trade Name	Combination Vaccines	1 date	2 date	3 date	4 date	5 date
Diphtheria, Tetanus, Pertussis	DTaP, DT, DTP	Infanrix, Daptacel	Pediarix, Pentacel, Kinrix					
Polio	IPV, OPV	IPOL	Pediarix, Pentacel, Kinrix					
Haemophilus influenza type 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	Prevnar, 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.

Gray shaded boxes above indicate that the child should not have received any more doses of that vaccine.

Record updated by:	Date	Record updated by:	Date

Minimum State Vaccine Requirements for Child Care Entry

By This Age:	Children Need These Shots:						
3 months	1 DTaP	1 Polio		1 Hib	1 Hep B	1 PCV	
5 months	2 DTaP	2 Polio		2 Hib	2 Hep B	2 PCV	
7 months	3 DTaP	2 Polio		2-3 Hib**	2 Hep B	3 PCV	
12-16 months	3 DTaP	2 Polio	1 MMR	3-4 Hib**	3 Hep B	4 PCV	1 Var
19 months	4 DTaP	3 Polio	1 MMR	3-4 Hib**	3 Hep B	4 PCV	1 Var
4 years or older (in child care only)	4 DTaP	3 Polio	1 MMR	3-4 Hib**	3 Hep B	4 PCV	1 Var
4 years and older (in kindergarten)	5 DTaP	4 Polio	2 MMR	3-4 Hib**	3 Hep B	4 PCV	2 Var

NC Child Care Health and Safety Resource Center