MEDICAL REPORT & IMMUNIZATION RECORD

Both the Medical Report and Immunization Record are required by NC State Law and need be to be completed by your child's physician and turned in at the start of school.

Name of Child ____ Date of Birth__________________

Parent or Guardian ____ Home Phone __________________

Address of Parent or Guardian ____

PART A – MEDICAL HISTORY: (May be completed by parent/guardian)

1. Is the child allergic to anything? NO _____ YES _____ If yes, what? ______________________________
   ____
2. Is the 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, what?: ______________________
   ____
4. Any previous hospitalizations or operations? NO _____ YES _____ If yes, when and for what? ____________
   ____
5. Any history of significant previous diseases or recurrent illness? NO _____ YES _____ If yes, please circle: Diabetes Convulsions Heart Trouble Asthma If others, what/when? ____________________________
   ____
6. Does the child have any physical disabilities? NO _____ YES _____ If yes, please describe: _____________
   ____
7. Does the child have any mental disabilities? NO _____ YES _____ If yes, please describe: _______________
   ____

Signature of Parent or Guardian: ____ Date:_________________

PART 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 DHHS standards for the 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 ________ Follow-up ________

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: ____

Physician's Name *(Printed)*: ____ Phone Number: _______________
Physician's Address: ____
City: ____________________________________ State: ___________ Zip Code: ________________

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Name of Child ____ **Date of Birth** ________________

PART C – IMMUNIZATION HISTORY:

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 DHHS standards for the EPSDT program.)

Enter the date each dose was received (Month/Date/Year) or attach a copy of the immunization records. G.S. 130A-155(b) requires child care facilities to have this information on file. Please refer to the Minimum State Vaccine Requirements for Child Care Entry and the additional Vaccine Recommended by the Advisory Committee on immunization practices listed below.

VACCINE Type	Vaccine Abbreviation	Trade Name	Combination Vaccine	1	2	3	4	5
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, PVP-23	Prevnar Pneumovax***						

Legend:
* Required by State Law for children born on or before 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 PVC vaccines.

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

Vaccines Recommended by the Advisory Committee on Immunization Practices (ACIP), But Not Required

Vaccine Type	Vaccine Abbreviation	Trade Name	Recommended Schedule	1	2	3	4	5
Rotavirus	RV, Rota	Roteteq, Rotarix	2 months, 4 months, 6 months					
Hepatitis A	Hep A	Havrix, Vaqta	12-23 months, then another dose within 6-18 months					
Influenza	Flu	Fluzone, Fluarix, FluLaval, Fluvirin, Flu Mist, Afluria	Annually after 6 months of age					

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 PVC	
5 Months	2 DTaP	2 Polio		2 Hib	2 Hep B	2 PVC	
7 Months	3 DTaP	2 Polio		2-3 Hib**	2 Hep B	3 PVC	
12-16 Months	3 DTaP	2 Polio	1 MMR	3-4 Hib**	3 Hep B	4 PVC	1 Var
19 Months	4 DTaP	3 Polio	1 MMR	3-4 Hib**	3 Hep B	4 PVC	1 Var
4 year old or older (in child care only)	4 DTaP	3 Polio	1 MMR	3-4 Hib**	3 Hep B	4 PVC	1 Var
4 year old and older (and in kindergarten)	5 DTaP	4 Polio	2 MMR	3-4 Hib**	3 Hep B	4 PVC	2 Var

Signature of Physician or Authorized Agent/Title: ________________________________ **Date:** __________

Physician or Authorized Agent's Name *(Printed)*: ________________________________