West Forsyth Christian Preschool
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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)

1. Is child allergic to anything? No_____
   If Yes, what? _____
2. Is child currently under a doctor's care? No_____
   If Yes, for what reason? _____
3. Is the child on any continuous medication? No_____
   If Yes, what? _____
4. Any previous hospitalizations or operations? No_____
   If Yes, when and for what? _____
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: _____
7. 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 #**_____

*Little children, **let us love**, not in word or speech, but in truth and action. 1 John 3:18 NRSV*

January 2021

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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	IPOL	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	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.

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					

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