HEALTH AND IMMUNIZATION FORM

Trinity Baptist Weekday Preschool

Child's Name_____Birth Date_____

Parent or Guardian Name_____

Parent or Guardian Address_____

_____

MEDICAL HISTORY (To be completed by parent or guardian)

1. Does your child have any allergies? ____Yes ____No
   If Yes, explain steps that should be taken in case of accidental exposure.

2. Is your child currently under a doctor's care? ____Yes ____No
   If Yes, please explain.

3. Is your child on any continuous medication? ____Yes ____No
   If Yes, please list the name of the medication(s) and the reason it is being given.

4. Has your child ever been hospitalized? ____Yes ____No
   If Yes, please list dates and reasons for hospitalization.

5. Does your child have any history of:
   *diabetes ____Yes ____No
   *convulsions ____Yes ____No
   *heart problems ____Yes ____No
   *significant disease or recurrent illness (please list) ____Yes ____No

   *other conditions (please list) ____Yes ____No

6. Does your child have any mental or physical disabilities? ____Yes ____No
   If Yes, please explain.

Signature of Parent or Guardian_____

-over-

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*__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, a certified nurse practitioner, or a public health nurse meeting *
*DEHNR standards for EPSDT programs. *
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Height_____ Weight_____ Head_____ Eyes_____Ears_____

Nose_____ Teeth_____Throat_____Neck_____Heart_____

Chest_____GU_____EXT_____Neurological System_____Skin_____

Results of Tuberculin Test, if given: ____Normal ____Abnormal _____Date

Should activities be limited? ____Yes ____No If Yes, please explain.

Any other recommendations?

Signature and title of authorized examiner_____

Date of Examination_____Phone Number_____

Office Address (may use stamp)

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*__Immunization History:__ The daycare operator or health official must enter the *
*date immunization was received in the space below or attach a copy of the *
* immunization record. G.S 130A-155 (b) requires all day care facilities to have *
* this information on file. *
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Enter date of each dose – month/day/year

VACCINE	DOSE 1	DOSE 2	DOSE 3	DOSE 4	DOSE 5
DPT or DT					
Polio					
MMR					
Hib					
Hepatitis B					
Other					