

Children's Medical Report and Immunizations

8501 Honeycutt Rd Raleigh, NC 27615 (919) 870-6616

This form does NOT need to be turned in with registration However it must be completed by the beginning of the school year. Immunization documentation and exam dates must be after 8/31/2024.

Name of Child: Age: Child's Birthdate: Name of Parent or Guardian:				
Medical History: to be completed by parent or 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, what?	100			
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 diabetes? No Yes convulsion No Yes heart trouble? No Yes asthma? No Yes other, what/when?	s?			
Does the child have any physical disabilities? No Yes If yes, please describe:				
2. Any mental disabilities? No Yes If yes, please describe:	-			
** Signature of Parent or Guardian Date				
2. Any mental disabilities? No Yes If yes, please describe:				
Weight: % Height: % HEENT: Heart:				
Teeth: Neuro:				
Results of PPD, if indicated:				
Recommendations:				
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Office Address Office Photo	ne Number			

Immunization History: Please complete or attach a immunization print out from your doctor.

Vaccine	Date	Date	Date	Date	Date
DTaP/DTP					
Hib					
IPV					
Нер В					
Нер А					
MMR					
Virivax					
Other					