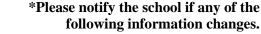


*Please notify the school if any of the following information changes.

By State Law, we must have all immunization records within 30 days of enrollment or the student is subject to suspension.

STUDENT MEDICAL REPORT

Student's Name	Birth date:	
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 Yes	If yes, what?	
2. Is the child currently under a doctor's care? N	No Yes If yes, for what reason?	
3. Is the child on any continuous medication? N		
4. Any previous hospitalizations or operations?	? No Yes If yes, when and for w	hat?
5. Any history of significant previous diseases of Diabetes? NoYes ; Convulsions? NoYes ; The others, what/when?	oYes; Heart trouble? NoYes _	
6. Does the child have any physical challenges?		
7. Any mental challenges? No Yes If	yes, please describe:	
Signature of Parent or Guardian:	Date	e:
B. Physical Examination: This examination must be authorized agent currently approved by the N.C. bordering states), a certified nurse practitioner, or program.	Board of Medical Examiners (or a compa	arable board from
Height% Weight%		
Head Eyes Ears	rs Nose	Teeth
Throat Neck Hear	art Chest	Abd/GU
Ext Neurological System	Skin	
Results of Tuberculin Test, if given: Type:	Date Normal A	lbnormal
Should activities by limited? No Yes If		
Any other recommendations:		
Signature of authorized examiner/title:		
Date of Examination	Phone: ()	





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IMMUNIZATION HISTORY

Enter date of each dose - Month/Day/Year							
VACCINE	#1	#2	#3	#4	#5		
* DTP/DT (circle which)							
* Polio							
** Hib							
***Hepatitis B							
* MMR (combined doses)							
****Chicken Pox							
OTHER							
OTHER							
*** Required by	y State law for o	children born on o children born on o children born on o	or after 7/1/94.				
	_	ds Updated b			pdated:		

Parents: By State Law, we must have all immunization records within 30 days of enrollment or the student is subject to suspension

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