CJP Children's Medical Report

Name of Child_____ Birthdate_____

Name of Parent or Guardian_____

Address of Parent or Guardian_____

A. Medical History (To be completed by parent)

1. Is child allergic to anything? No___ Yes___ If yes, to what?_____
   _____
2. Is child currently under a doctor's care? No__Yes___If yes, for what reason?_____
   _____
3. Is 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__; Diabetes? No__ Yes__; Convulsions? No__ Yes__; Heart trouble? No __Yes__. If others, what? _____
6. Does child have any physical disabilities? No__Yes___If yes, please describe:_____
   _____
7. Does child have 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, an 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 DEHNR standards for EPSDT program.

Height_____% Weight_____% Head_____ Eyes_____ Ears_____ Nose_____ Teeth_____ Throat_____

Neck_____ Heart_____ Chest_____ Abd/GU_____ Ext_____ Neurological System_____ Skin_____

Results of Tuberculin Test if given: Type_____date_____Normal_____Abnormal_____

Should activities be limited? No___ Yes_____ If yes, explain:_____

_____

Any other recommendations:_____

Is this child up to date on all of his/her immunizations? Yes____ No_____ If no, please explain:_____

_____

Signature & title of authorized examiner_____

Phone number:_____ Date of exam:___/___/_____

Immunization Record

IMMUNIZATION HISTORY *The day care 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*

Enter date of each dose- Month/Day/Year

Vaccine	#1	#2	#3	#4	#5
DTaP/DTP (Infanrix, Daptacel, Pediarix, Pentacel, Kinrix)					
POLIO/IPV/OPV (IPOL, Pediarix, Pentacel, Kinrix)					
HIB (Act HIB, Pedvax, Pentacel)					
MMR (MMR II, Proquad)					
Hepatitis B (HepB, HBV, Engerix-B, Recombivax HB, Pediarix)					
Varicella (Var, Varivax, Proquad)					
PCV (PCV-13, PPV-23)					

Completed Medical Report must be submitted no later than July 23, 2018 for our full day families and August 17, 2018 for our half day families.

Medical Reports may be faxed to: 704.944.6898

What Shots Do They Need?

By This Age……Children *MUST* have these shots

12-16 Months	3 DTaP	2 Polio	3-4 Hib	1 MMR	3 Hep B	4 PCV	1 Var +
19 Months	4 DTaP	3 Polio	3-4 Hib	1 MMR	3 Hep B	4 PCV	1 Var +
4 years or older	4 DTaP	3 Polio*	3-4 Hib**	2 MMR	3 Hep B	4 PCV**	1 Var +

*Children must receive their last DTaP, Polio, and MMR before they start kindergarten and after age 4

**Children beyond their 5th birthday are not required to receive Hib or PCV vaccines

+Vaccination required unless documentation of disease history. Acceptable documentation is a letter from the child's parent, legal guardian or physician stating approximated date or age of child's infection

Note: Prevnar, Pneumococcal and Flu Vaccines are not required or reportable but are recommended by the Advisory Committee on Immunization Practices.