

CHILD'S PHYSICIAN MUST COMPLETE THIS SIDE

Immunization History (Enter date each immunization was received)

DTP series 1	2	3	4	5
Polio 1	2	3	4	5
Measles 1	2	3	4	5
German Measles (Rubella)			Typhoid	
Small Pox			Mumps	
Tetanus Booster			Others	

State Law, G.S. 130-87 requires three DPT's and three doses of oral polio vaccine by age; and measles vaccine before age two.

Parents, you may send in your child's immunization card and the Pre-School director will copy it and return it to you instead of completing immunization history.

Medical Examination

Weight _____ Height _____ Blood Pressure _____

Lungs _____ Throat _____ Neck _____

Heart _____ Abdomen _____ Hernia _____

Extremities _____ Posture (spine) _____ Skin _____

Neurological System _____

Eyes _____ Glasses _____ Ears _____ Nose _____

Hair _____ Teeth _____ Head _____

Allergies (please list) _____

Tuberculin test, if given _____

General Appraisal _____

Special Considerations _____

I have examined this child herein described and have reviewed his health history. It is my opinion that he is physically able to engage in Pre-School activities, except as noted above.

Physician's Name _____ Phone _____

Physician's Address _____

Date _____