



1165 Weaver Dairy Road  
Chapel Hill, NC 27514-1576  
(919) 929-3339

<b>HEALTH INFORMATION</b>	
(Please print.)	
<b>Child's Name:</b>	
<b>Child's Sex:</b>	<b>Child's Birth Date:</b>
<b>Child's Home Address:</b>	
<b>Parent(s) / Guardian(s) Name(s):</b>	

### Record of Immunizations

*(Either fill in the following information, or attach a photocopy of your child's updated NC Dept of Health and Human Services Lifetime Immunization Record.)*

VACCINE	DOSE	DATE RECEIVED		
		Month	Day	Year
Diphtheria, Tetanus, & Pertussis	1			
	2			
	3			
	4			
	5			

VACCINE	DOSE	DATE RECEIVED		
		Month	Day	Year
Haemophilus Influenzae Type B	1			
	2			
	3			
	4			

VACCINE	DOSE	DATE RECEIVED		
		Month	Day	Year
Polio	1			
	2			
	3			
	4			

VACCINE	DOSE	DATE RECEIVED		
		Month	Day	Year
Prennar	1			
	2			
	3			
	4			

VACCINE	DOSE	DATE RECEIVED		
		Month	Day	Year
Hepatitis B	1			
	2			
	3			

VACCINE	DOSE	DATE RECEIVED		
		Month	Day	Year
Measles, Mumps, & Rubella	1			
	2			

VACCINE	DOSE	DATE RECEIVED		
		Month	Day	Year
Varicella	1			
	2			

VACCINE	DOSE	DATE RECEIVED		
		Month	Day	Year
Hepatitis B Immune Globulin	1			

### History of Virus Infection/Exposure

- Chicken Pox     
  Measles     
  German Measles     
  Rheumatic Fever     
  Scarlet Fever  
 Whooping Cough     
  Tuberculosis     
  Recent exposure to communicable disease: \_\_\_\_\_

### Medical History

- Epilepsy     
  Diabetes     
  Medications taken on a routine basis: \_\_\_\_\_  
 Drug Sensitivity: \_\_\_\_\_     
  Allergies: \_\_\_\_\_  
 Behavioral or emotional problems: \_\_\_\_\_

### Comprehensive Physical Examination

This child has been given a comprehensive physical examination and has been found to be in good physical health, with the following exceptions: \_\_\_\_\_

Remarks and recommendations: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician's Telephone Number: \_\_\_\_\_

Physician's Address: \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date