



3639 Old Chapel Hill Road * Durham, NC 27707 * (919) 489-8432 * www.wsycdurham.com

PART I & II TO BE COMPLETED BY PARENT OR GUARDIAN

I. PERSONAL DATA

CHILD'S NAME _____
(Last) (First) (Middle)
BIRTHDATE _____ SEX (male or female) _____
NAME OF PARENT(S) OR GUARDIAN(S) _____
ADDRESS OF PARENT(S) OR GUARDIAN(S) _____

II. HEALTH AND BEHAVIORAL HISTORY

List all allergies your child has (e.g., food, insect stings, medicines, pollens, etc.) _____

Where does your child get regular health care? Doctor's Name or Agency: _____

Address: _____ Telephone Number: _____

List any condition, continuous medication, or health problem for which your child is currently receiving medical care: _____

List all illnesses, injuries, or behavioral difficulties that require hospitalization your child has or has had: _____

Has your child ever had an evaluation at a developmental evaluation center, by a psychologist or other health specialist?

Yes _____ No _____ If yes, list type of evaluation and approximate age of child _____

SIGNATURE OF PARENT(S) OR GUARDIAN(S) _____ DATE _____

III. IMMUNIZATIONS

(TO BE COMPLETED ONLY BY DOCTOR OR OTHER APPROPRIATE HEALTH CARE OR SCHOOL PERSONNEL)

RECORD OF IMMUNIZATION (Enter date of EACH dose - MM/DD/YY)					
VACCINE	# 1	# 2	# 3	# 4	# 5
Hepatitis B					
Polio/IPV					
DTaP					
Hib					
PCV					
MMR					
Varicella					

North Carolina Immunization Law require that all children must get certain vaccines. This helps protect themselves and others from getting sick.

I CERTIFY THIS CHILD HAS RECEIVED THE IMMUNIZATIONS AS NOTED ABOVE.

Doctor/Health Care Provider Signature: X _____ Date: _____

Check One: Medical Personnel _____ or School Personnel _____

ATTN: Doctors & Health Care Providers: Please sign on the front and back of this form.

IV. HEALTH ASSESSMENT

A. Height: ____ ft. ____ in. percentile ____ Weight: ____ lbs. percentile ____ Blood Pressure: ____ / ____

B. Screening:

1. Vision

2. Hearing (Pass ____ or Fail ____)

Pure Tone: ____ dB level (usually 20dB)

With glasses: Yes ____ No ____

3. Development (optional)

Test(s) Used: _____

Within Normal Range ____ Needs Follow Up ____

C. Hemoglobin/Hematocrit (if indicated) Normal ____ Abnormal ____

TB Skin Test (if indicated) Normal ____ Abnormal ____

D. Please check any of the following illnesses or behavioral difficulties the child has or has had:

____ Asthma

____ Cystic Fibrosis

____ Hearing Problems

____ Bleeding Problems

____ Cerebral Palsy

____ Meningitis

____ Bone/Muscle Problems

____ Dental Problems

____ Sickle Cell Anemia

____ Bowel Problems

____ Diabetes

____ Skin Problems

____ Cancer/Leukemia

____ Ear Infections

____ Speech Problems

____ Convulsions/Seizures

____ Heart Problems

____ Stomach Aches

E. List any allergies this child has (e.g., food, insect stings, medicine, pollens, etc.) _____

F. List any medical, dental, developmental conditions, or disabilities which this child has and the extent to which these conditions might affect the child's performance at school: _____

G. Does this child take medication on a regular basis? Yes ____ No ____ If yes, list medicine and possible side effects:

Does medication need to be given at school? Yes ____ No ____ If yes, list frequency and duration: _____

H. List any other health considerations needed for this child while in school: _____

X

Signature of Doctor/Health Care Provider

Date

Address

Phone No.