

Children's Physical Form

Name of Child _____ Age _____ Birth Date _____
 Name of Parent/Guardian _____
 Address of Parent/Guardian _____
 (Street) _____

 (City) _____ (State) _____ (Zip) _____

A. MEDICAL HISTORY (May be completed by parent)

1. Previous hospitalization: Yes _____ No _____ If so, what? _____
 2. Is child allergic to anything: Yes _____ No _____ If so, what? _____
 3. Any previous diseases or illness: Yes _____ No _____ If so, what? _____
 4. Any operations: Yes _____ No _____ If so, what? _____
 5. Any physical handicaps: Yes _____ No _____ If so, please describe: _____
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6. Is child under care of a doctor: Yes _____ No _____
 7. Any history of mental retardation: Yes _____ No _____
 8. Any history of convulsions: Yes _____ No _____
 9. Any history of diabetes in family: Yes _____ No _____
 10. Any history of heart trouble: Yes _____ No _____

(Parent's Signature)

B. PHYSICAL EXAMINATION: This examination must be completed and signed by a licensed physician or his or her authorized agent who is currently approved by the Georgia Board of Medical Examiners.

Weight _____ Height _____ Heart _____
 Chest _____ Throat _____ Neck _____ Abdomen _____ GU _____
 Ext. _____

Neurological System _____
 Teeth _____ Skin _____ Head _____ Eyes _____ Ears _____

Results of Tuberculin Test, if given: _____
 (Type) _____ (Results) _____

Should activities be limited? _____

Recommendations: _____

 (Signature of physician or authorized agent who is currently approved by the Georgia Board of Medical Examiners)

 Date of Examination

 Office Address

 Telephone Number

C. IMMUNIZATION HISTORY: The day care operation must enter the date each immunization was received. G.S. 130-90 (B) requires all educational facilities to have this information on file.

VACCINE	DATE	DATE	DATE	DATE	DATE
*DPT					
Td or Tetanus					
*Polio, oral					
*Rubeola (measles) 1					
Mumps					
*Rubella (German Measles)					
MMR					

Required by State law. I.G.S. 130-87 (b) requires measles vaccine to be given on or after the first birthday.