

**LIBERTY BAPTIST DAYCARE
MEDICAL EXAMINATION**

STUDENT'S NAME: _____ S.S.

_____ BIRTHDATE: _____

PARENTS OR
GUARDIAN: _____

ADDRESS: _____

_____ Street/PO Box # City State Zip

MEDICAL HISTORY: Allergies _____ Chickenpox _____ Diabetes _____ Drug
Sensitivities _____
Epilepsy _____ Measles _____ Mumps _____ Rheumatic
Fever _____
Tuberculosis _____ Whooping Cough _____ Other _____

PX: _____ HEAD: _____ EYES: _____ Vision

R _____ L _____

EARS: _____

HEARING: _____

NOSE: _____ MOUTH: _____

THROAT: _____ ADENOIDS: _____ TONSILS: _____

HEART: _____ BLOOD

PRESSURE: _____

LUNGS: _____

ABDOMEN: _____ HERNIA: _____

EXTREMITIES: _____

GENITALIA: _____

IMMUNIZATION DATA

Minimum Requirements:

D.P.T. (5 Required) (1) _____ (2) _____ (3) _____ (4) _____ (5) _____

Polio (4 Required) (1) _____ (2) _____ (3) _____ (4) _____

Measles (*Must be AFTER FIRST BIRTHDAY): (1) _____ (2) _____

*Date of Repeat Measles vaccination if date above was before 1st birthday _____

Rubella: _____ HIB (1) _____ (2) _____ (3) _____

(4) _____

Hepatitis B (1)_____ (2)_____ (3) _____

Varicella _____

Pevnar _____

Any known Allergies:

RECOMMENDATIONS: _____

Date

Physician's Signature

Approved: N.C. State Medical Society
N.C. Dept. Of Public Instruction
N.C. State Board of Health