Westminster School for Young Children
3639 Old Chapel Hill Road
Durham, NC 27707
(919) 489-8432

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 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
DTP					
DTP					
OPV					
Hib					
MMR					
Measles					
Mumps					
Rubella					
Hepatitis B					

Exemptions from NC State Immunization Law require that a statement must be on file at school in student's permanent record. Exemptions must meet requirements of the law. Consult your local Health Department.

Medical _____

Religious _____

STATE LAW REQUIRES THE FOLLOWING MINIMUM DOSES:

- 5 DTP/DT SHOTS (If 4th dose is after 4th birthday, 5th dose is not required.)
- 4 ORAL POLIO VACCINE DOSES (If 3rd dose is after 4th birthday, 4th dose is not required.)
- 1 Hib – At least 1 Hib on/after 1st birthday and before 5 years of age. (Not required after age 5)
- 2 MMR doses (1st dose on/after 1st birthday)

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.

THIS SIDE TO BE COMPLETED BY DOCTOR OR OTHER APPROPRIATE HEALTH CARE PERSON

IV. HEALTH ASSESSMENT

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

B. Screening:

1. Vision

With glasses: Yes _____ No _____

2. Hearing (Pass _____ or Fail _____)
Pure Tone: _____ dB level (usually 20dB)

3. Development (optional) Test(s) Used: _____
Within Normal Range _____ Needs Follow Up _____

C. Hemoglobon/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.

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