



DOCTOR'S PHYSICAL EXAM

This **examination must be completed and signed by a licensed physician or, physician's authorized agent** as currently approved by a state Medical Board, Examiners, a certified nurse practitioner, or a public health nurse meeting DEHNR standards for EPSDT program. **THIS FORM IS REQUIRED TO BE UPDATED ANNUALLY BY NC DIVISION OF CHILD DEVELOPMENT.**

Head _____ Eyes _____ Ears _____ Nose _____ Teeth _____
 Throat _____ Neck _____ Heart _____ Chest _____ GU _____
 Ext _____ Neurological System _____ Skin _____

Results of Tuberculin Test, if given:

No _____ Yes _____ Normal _____ Abnormal _____

Should activities be limited? No ___ Yes ___ If yes, explain

Any other recommendation _____

<p>C. Immunization History: The day care operator or health official must enter the date immunization was received in the space below or attach a copy of the immunization record. G.S. 130A-155 requires all day care facilities to have this information on file.</p> <p style="text-align: center;">Enter date of each dose - Month/Day/Year</p>					
VACCINE	#1	#2	#3	#4	#5
*DTP/DI					
*Polio					
**Hib					
*MMR (combined doses)					
Measles (single dose)					<p>Required by State law.</p> <p>Required by State law for children born on or after 10/1/91.</p>
Mumps (single dose)					
Rubella (single dose)					
Hep B					
Varicella					
PCV 7					
Other					

Signature of Examiner/Title

Date of Examination

Phone