

\*\*\*This form must be turned in before your child can attend The Weekday School.\*\*\*

## The Weekday School Medical Form 2020-21

First United Methodist Church, 204 Sixth Avenue West, Hendersonville, NC 28739  
www.fumchvnc.org    deborah@hvlfumc.org    828/692-6673 School    828/693-4275 Church

### IMMUNIZATIONS

**PARENTS ... Please submit a current certificate of immunization.**

**It is Church policy that we DO NOT accept EXEMPTIONS for immunizations.**

The School is responsible for accurately reporting children's immunizations to the State of North Carolina. North Carolina state law requires the following: "A certificate of immunization should be presented to the child care operator for each child who attends the facility. The child care operator should check the certificate to ensure the child meets immunization requirements." The law further states, "If a child's immunization record lacks evidence of required vaccination, the parent or guardian must be notified about the deficiency."

If an immunization record is incomplete, the School must notify the parents in writing that the file must be completed and/or updated. Written verification of proper immunization must be received within 30 days of notice, or child care will be terminated.

Date of Exam \_\_\_\_\_

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian's Name(s) \_\_\_\_\_ Date of This Exam \_\_\_\_\_

### MEDICAL HISTORY

1. Previous hospitalizations? Yes \_\_\_ No \_\_\_ If so, why? \_\_\_\_\_

2. Serious illness/operation? Yes \_\_\_ No \_\_\_ If so, what? \_\_\_\_\_

3. Physical handicaps? Yes \_\_\_ No \_\_\_ If so, describe \_\_\_\_\_

4. Allergies? Yes \_\_\_ No \_\_\_ If yes, specify prescribed treatment \_\_\_\_\_

5. Is child under doctor's care? Yes \_\_\_ No \_\_\_ If so, why? \_\_\_\_\_

6. Any history of medical condition affecting mental/physical development? Yes \_\_\_ No \_\_\_

7. Any family history of seizures or fainting? Yes \_\_\_ No \_\_\_

8. Any history of diabetes in the family? Yes \_\_\_ No \_\_\_

9. History of heart condition? Yes \_\_\_ No \_\_\_

### PHYSICAL EXAMINATION

Height \_\_\_\_\_ Weight \_\_\_\_\_ Heart \_\_\_\_\_ Chest \_\_\_\_\_  
Throat \_\_\_\_\_ Neck \_\_\_\_\_ Abdomen \_\_\_\_\_ GU \_\_\_\_\_  
Ext \_\_\_\_\_ Neuro \_\_\_\_\_ Teeth \_\_\_\_\_ Skin \_\_\_\_\_  
Head \_\_\_\_\_ Eyes \_\_\_\_\_

Should activities be limited? \_\_\_\_\_ Recommendations \_\_\_\_\_

1/2020 Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

\*\*\* A \$110 non-refundable registration fee, completed registration form, and immunization record must accompany this form for your child to fully be registered. \*\*\*