Kids and Company
Medical Record

Child's Name _____ Date of Birth _____

Parent's Name _____

Address _____

A. Medical History – To be completed by Parent

1. Is child allergic to anything? ☐ Yes ☐ No

   If yes, what? _____

2. Is child currently under a doctor's care? ☐ Yes ☐ No

   If yes, for what reason? _____

3. Is the child on any continuous medication? ☐ Yes ☐ No

   If yes, what? _____

4. Any previous hospitalizations or operations? ☐ Yes No

   If yes, when & for what? _____

5. Any history of: Significant previous diseases or recurrent illness ☐ Yes ☐ No

   Diabetes ☐ Yes ☐ No Convulsions ☐ Yes ☐ No

   Heart Trouble ☐ Yes ☐ No If others, what / when? _____

   _____

6. Does the child have any physical disabilities? ☐ Yes ☐ No
   Does the child have any mental disabilities? ☐ Yes ☐ No

   If yes, please describe: _____

Parent Signature _____ **Date**_____

Physical Examination: **This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the NC Board of Medical Examiners (or a comparable board from bordering states), a certified nurse practitioner, or a public health nurse meeting DEHNR standards for EPSDT program.**

Height _____% Weight _____%

Head _____ Eyes _____ Ears _____ Nose _____ Teeth _____ Throat _____

Neck _____ Heart _____ Chest _____ Abd/GU _____ Ext _____ Skin _____

Neurological System _____ Should activities be limited? ☐Yes ☐No

Results of TB test, if given: Type _____ Date _____ ☐ Normal ☐ Abnormal

Any other recommendations: _____

Date of Examination _____ Phone Number _____

Signature of Authorized Examiner / Title _____