Children's Medical Report

Name of Child_____Birthdate_____
Name of Parent or Guardian_____
Address of Parent or Guardian_____

A. Medical History (May be completed by parent)

1. Is child allergic to anything? No ___ Yes ___ If yes, what? _____
   _____
2. Is child currently under a doctor's care? No ___ Yes___ If yes, for what reason?
   _____
3. Is the child on any continuous medication? No ___ Yes ___ If yes, what?
   _____
4. Any previous hospitalizations or operations? No ___ Yes ___ If yes, when and for what?
   _____
5. Any history of significant previous diseases or recurrent illness? No _____ Yes _____, diabetes No ___ Yes ___, convulsions No ___ Yes ___, heart trouble No __ Yes _____
   If others, what/when?_____
6. Does the child have any physical disabilities? No ___ Yes ___ If yes, please describe:
   _____

B. Physical Examination: This examination must be completed and signed by a licensed physician, his authorized agent currently approved by the N.C. 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 _____
Neurological System _____ Skin _____
Results of Tuberculin Test, if given: Type _____ Date _____ Normal _____ Abnormal ____
Should activities be limited? No _____ Yes _____ If yes, explain: _____
_____
Any other recommendations: _____
_____
Signature of authorized examiner/title _____
Date of Examination _____Phone # _____

Office Address
(may use address stamp)