Children's Medical Report

Name of Child_____ Birthdate _____
Name of Parent or
Guardian_____
Address of Parent of 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:_____
Any mental disabilities? No___ Yes___ If yes, please describe:_____

Signature of Parent or
Guardian_____ **Date**_____

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: (Please indicate any chronic illnesses or medical conditions)
_____
_____

Date of Examination_____

Signature of Authorized Examiner:_____
Title_____ **Address**_____
Phone #_____ Revised 3-03