

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: _____

7. Any mental disabilities? No ___ Yes ___ If yes, please describe: _____

Signature of Parent or Guardian _____

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.

Head _____ Eyes _____ Ears _____ Nose _____ Teeth _____

Throat _____ Neck _____ Heart _____ Chest _____ 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)