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 mental or physical 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: _____

_____ **Date of Examination**_____

Signature of authorized examiner/title_____ **Phone #**_____

☆ **DON'T FORGET!** We need a copy of your child's **full immunization record** to keep in your child's file! Please ask your child's physician for an up-to-date copy for our records, if you haven't already done so!