

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 ___; asthma 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 DHHS standards for EPSDT program.
Height _____% Weight _____%

Head _____ Eyes _____ Ears _____ Nose _____ Teeth _____ Throat _____
Neck _____ Heart _____ Chest _____ Abd/GU _____ Ext _____
Neurological System _____ Skin _____ Vision _____ Hearing _____
Results of Tuberculin Test, if given: Type _____ date _____ Normal ___ Abnormal ___ followup _____

Developmental Evaluation: delayed _____ age appropriate _____
If delay, note significance and special care needed: _____

Should activities be limited? No ___ Yes ___ If yes, explain: _____
Any other recommendations: _____

Date of Examination _____

Signature of authorized examiner/title _____ Phone # _____