

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: _____

7. Does the child have 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.

Height _____% Weight _____% Head _____ Eyes _____ 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 _____

Office address (may be stamped)

Title _____ Phone # _____

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