Children's Medical Report

Name of Child _____ Birth Date _____

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, when/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 _____

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 #** _____