CHILDREN'S MEDICAL REPORT

Name of the child ________________________________ Birth date________________
Name of Parent or Guardian ____
Address of the 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, what? __________
____
3. Is the child on any continuous medication? No ___ Yes ___ If yes, what? _________
____
4. Any previous hospitalizations or operations? No ___ Yes ___ If yes, what? _______
____
5. Any history of significant previous diseases or recurrent illness? No ____ Yes ____:
Diabetes No ___ Yes ___; convulsions No ___ yes ___; heart trouble No ___ yes ____
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 NC 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: ___________________
____
____

Date of Examination ______________________________
Signature of authorized examiner/ title ___________________ Phone # _________