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:
____
7. 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, their 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 # _________