12/99

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: _____

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 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 #** _____