

Child's Medical Report



Name of Child _____ Birth Date _____

Name of Parent/Guardian _____

Address of Parent/Guardian _____

I. MEDICAL HISTORY (may be completed by parent)

Does the child have any allergies? Yes No If yes, what? _____

Is child currently under a doctor's care? Yes No If yes, for what reason _____

Is the child on any continuous medication? Yes No If yes, what? _____

Any previous hospitalizations or operations? Yes No If, yes, when and for what? _____

Any history of significant previous diseases or recurrent illness? Yes No

Diabetes Yes No Convulsions Yes No Heart Trouble Yes No

If others; what/when? _____

Does child have any physical disabilities? Yes No If yes, please describe _____

Does child have any mental disabilities? Yes No If yes, please describe _____

Signature of Parent/Guardian _____ Date _____

II. PHYSICAL EXAMINATION: *This examination must be completed and signed by a licensed physician, or 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 _____ Skin _____ Neurological System _____

Results of Tuberculin Test, if given: Type _____ Date _____ Normal Yes No

Should physical activities be limited? Yes No If yes, please explain _____

Any other recommendations: _____

Signature of authorized examiner & title _____

Date of examination _____ Office phone _____

Office address (may use stamp) _____

*******PLEASE ATTACH RECORD OF CHILD'S IMMUNIZATIONS*******