

Children's Medical Report

Name of Child: _____ DOB: _____

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, 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 _____

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 _____ Chest _____ Abd/GU _____ Ext _____ Neurological System _____ Skin _____

Results of Tuberculin Test, if given: Type _____ Date _____ Normal _____ Abnormal _____

Any other recommendations: _____

Signature of authorized examiner: _____ Title: _____

Date of Examination: _____ Phone #: _____

Office Address
(may use address stamp)

