

# Children's Medical Report

Name of Child \_\_\_\_\_ Birthdate \_\_\_\_\_

Name of Parent or Guardian \_\_\_\_\_

Address of Parent or Guardian \_\_\_\_\_

## A. Medical History (May be completed by parent or guardian)

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 \_\_\_

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 \_\_\_\_\_ 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 # \_\_\_\_\_



