Child Medical Report

Child's Name:_____
Birthday: _____
Parent/Guardian's Name:_____
Parent/Guardian's Address:_____

A. Medical History (To be completed by parent/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 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 diseases or recurrent illness? No___ Yes___ Check if applicable: Diabetes___ Convulsions___ Heart trouble___ If others, what and when?
_____
6. Does the child have any physical disabilities? No___ Yes___ If yes, please describe.
_____
7. Does the child have any mental disabilities? No___ Yes___ If yes, please describe.
_____

Signature of Parent/Guardian:_____ Date:_____

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____	Heart____
Chest____	Abd/GU____	Ext____	Skin____

Neurological System_____

Results of Tuberculin Test, if given:
Type_____ Date_____ Normal_____ Abnormal_____
Should activities be limited? No_____ Yes_____ If yes, Explain_____
_____
Any other recommendations?_____

Signature & Title of Authorized Examiner_____
Date of examination:_____ Phone No.:_____