# 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)

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___; Asthma No___ Yes___.
If others, what/when? _____

6. Does the child have any physical disabilities: No___ Yes___ If yes, please describe:_____
_____

7. 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 DHHS standards for EPSDT program.

Height _____% Weight _____%
Head_____ Eyes_____ Ears_____ Nose_____ Teeth_____Throat_____
Neck_____ Heart_____Chest_____Abd/GU_____Ext_____
Neurological System_____Skin_____Vision_____Hearing_____
Results of Tuberculin Test, if given: Type_____date_____ Normal___Abnormal_____followup_____

Developmental Evaluation: delayed_____age appropriate_____
If delay, note significance and special care needed;_____
_____

Should activities be limited? No___ Yes___ If yes, explain:_____
Any other recommendations:_____
_____
_____

**Date of Examination_____**

**Signature of authorized examiner/title_____Phone #_____**