

# 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, for 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:  
\_\_\_\_\_  
\_\_\_\_\_
- Any mental disabilities? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, please describe: \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

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## 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 \_\_\_\_\_ Follow up \_\_\_\_\_

Developmental Evaluation: Delayed \_\_\_\_\_ Age Appropriate \_\_\_\_\_  
If delayed, note significance and special care needed: \_\_\_\_\_  
\_\_\_\_\_

Should activities be limited? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Examination \_\_\_\_\_

Signature of Authorized Examiner/Title \_\_\_\_\_ Phone \_\_\_\_\_

