

# Children's Medical Report

Name of Child \_\_\_\_\_ Birthdate \_\_\_\_\_  
Name of Parent or Guardian \_\_\_\_\_  
Address of Parent of 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: \_\_\_\_\_

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 \_\_\_\_\_

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