

# 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: \_\_\_\_\_

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 # \_\_\_\_\_