Children's Medical Report

Name of Child **Birthdate**

Name of Parent or Guardian **Address of Parent or Guardian**

Medical History

May be completed by a parent

Is the child allergic to anything? YES/ NO **If yes, list what the child is allergic to**

Is the child currently under a doctor's care? YES/ NO **If yes, list the reason(s)**

Is the child on any continuous medication? YES/ NO

If yes, list the medication(s)

Has the child had any hospitalizations/ operations? YES/ NO

If yes, write the date & list the reason(s)

Does the child have any history of significant previous disease or recurrent illness? NO/YES

Diabetes YES/ NO **Convulsions YES/ NO**

Heart Trouble YES/ NO **Asthma YES/ NO**

List any other disease(s) or illnesses and when it/ they occured

Does the child have any physical disabilities? YES/ NO

Describe if yes

Does the child have any mental disabilities?

Describe if yes

Signature of Parent or Guardian **Date**

Physical Examination

This examination must be completed and signed by one of the following: a licensed physician, the child's authorized agent currently approved by the N.C. Board of Medical Examiners (or comparable board from bordering states), a certified nurse practitioner, or a public health nurse meeting the DHHS standards for the 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:

Type **Date** **Normal/ Abnormal** **Followup**

Development Evaluation:

Delayed **Age Appropriate**

If delay, note significance and special care needed;

Should activities be limited? YES/ NO **If Yes, Explain**

Additional recommendations

Date of Examination

Signature of authorized examiner/ title **Phone Number**