Child's Medical Report

*The front + back of this form must be completed before your child starts.

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___.
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 _____

*Part B. must be filled out by a doctor.

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 practicioner, or a public health nurse meeting DEHNR standards for EPSDT program. Height _____% Weight _____%

Head_____ Eyes_____ Ears_____ Nose_____ Teeth_____

Throat_____ Neck_____ Heart_____ Chest_____ Abd/GU_____

Ext_____ Neurological System_____ Skin_____

Results of Tuberculin Test, if given: Type_____ date_____ Normal___ Abnormal___

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

Any other recommendations: _____

_____

Signature of authorized examiner/title _____

*Must be a doctor's signature.

Date of Examination_____ Phone #_____

(Continued on back) - Immunization Records

Office Address
(may use address stamp)