

# Children's Medical Report

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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, 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: \_\_\_\_\_

Has the child been screened for lead at 12 and 24 months of age, or once before the age of six? No \_\_\_ Yes \_\_\_

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

Signature of authorized examiner/title \_\_\_\_\_ Phone # \_\_\_\_\_