Children's Medical Report

Name of Child ____ Date of Birth ______________________

Name of Parent(s) / Guardian(s) ____

Address of Parent(s) / Guardian(s) ____

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 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. Has child had chicken pox? No ____ Yes ____

7. Does 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 ____

B. PHYSICAL EXAMINATION

This examination must be completed and signed by a licensed physician, his/her 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 DEHNR standards for EPSDT program.

Height ____________ Weight ____________
Head ____________ Eyes ____________ Ears ____________ Nose ____________ Teeth ____________
Throat ____________ Neck ____________ Heart ____________ Chest ____________ Abd/GU ____________
Ext ________ Neurological System _________

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 ____

Date of Examination _________________ Phone __________________________

Children’s Medical Report

C. IMMUNIZATIONS HISTORY: Fill in below or attach copy of the immunization record.

G.S. 130A-155(b) requires all day care facilities to have this information on file.

Enter date of each dose – Month/Day/Year

VACCINE

*DTP/DT (circle which) #1. ________ #2. ________ #3. ________ #4. ________ #5. ________

* Polio #1. ________ #2. ________ #3. ________ #4. ________

** Hib #1. ________ #2. ________ #3. ________ #4. ________

* MMR (combined doses) #1. ________ #2. ________

Measles (single dose) _________

Mumps (single dose) _________

Rubella (single dose) _________

OTHER _________ _________ _________ _________

* Required by State law.

**Required by State law for children born on or after 10/01/91