DCD 0108

12/99 Children’s Medical Report

Name of Child Birthdate Name of Parent or Guardian Address of Parent of Guardian

1. **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?

1. Any previous hospitalizations or operations? No Yes If yes, when and for what?
2. 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?

1. 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 Any other recommendations:

Yes

If yes, explain:

**Date of Examination**

# Signature of authorized examiner/title Phone #