Children's Medical Report

Name of Child____Birth date________
Name of Parent or Guardian____
Address of Parent or Guardian____

A. Medical History (to be completed by parent):

1. Does child have any allergies? _____ No _____Yes. If yes, what?
   ____
2. Is child currently under a doctor's care ? _____No _____Yes, if yes
   what for? ____
3. Is the child on any daily medication? _____No _____Yes, if yes what?
   ____
4. Any previous hospitalizations or operations? _____No _____Yes, if yes
   When and what for?____
5. Any history of significant previous diseases or recurrent illness? _____No
   _____Yes Diabetes: _____No _____Yes Convulsions: ___No ___Yes
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/her authorized agent currently approved by the North Carolina 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______ GI/GU____/______ Ext______________ Skin______________________

Neurological__________

Results of Tuberculin Test, if given: type________ date_________ Positive________
Negative_______
Should activities be limited? ______No ______Yes, if yes explain_______________
____
Any other recommendations:____
____
____
Has this child been screened for lead? ______No ______Yes

Signature of authorized examiner/title_______________________ Phone#____________

Revised 3-03

Immunization History

Name: ______________________________ **Date of Birth:** ____________________

Enter the date an immunization was received in the space below or attach a copy of the immunization record. G.S. 130A-155(b) requires all child care facilities to have this information on file.

Enter date of each dose - Month/Day/Year

*DTP / DT (circle which)					
*Polio					
**Hib					
***Hepatitis B					
*MMR (combined doses)					
****Chicken Pox					
OTHER					
OTHER					

*Required by State law.
**Required by State law for children born on or after 10/1/88.
***Required by State law for children born on or after 7/1/94.
****Required by State law for children born on or after 4/1/01.

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