

# Children's Medical Report

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 \_\_\_\_\_ 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 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: \_\_\_\_\_

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

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

## 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**

| VACCINE                  | #1 | #2 | #3 | #4 | #5 |
|--------------------------|----|----|----|----|----|
| *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.

[illegible]