PLEASE ATTACH YOUR CHILD'S IMMUNIZATION RECORD

Children's Medical Report

Name of Child_____Birthdate_____
Name of Parent or Guardian_____
Address of Parent or Guardian_____

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,
4. what?
   _____
   _____
5. Any previous hospitalizations or operations? No____ Yes____ If yes, when and for what?
   _____
   _____
6. Any history of significant previous diseases or recurrent illness? No____ Yes____ If yes, when and for what?
   _____
   _____
7. Does the child have any physical disabilities? No____ Yes____ If yes, please describe:_____

Signature of Parent or Guardian_____Date_____

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_____Nose_____Teeth_____
Throat_____Neck_____Chest_____Abd/GU_____
Ext_____Neurological System_____Skin_____
Results of Tuberculin Test, if given: Type_____Date_____Normal_____
Abnormal_____
Should any activities be limited? No____Yes_____If yes, explain:_____
Any other recommendations:_____
Date of examination:_____

Signature of authorized examiner/title_____Phone#_____