

Date of Enrollment\_\_\_\_\_

### CHILD'S MEDICAL REPORT

To be completed and placed on file prior to enrollment

Name of Child \_\_\_\_\_ Birth Date \_\_\_\_\_  
Last First Middle

Name of Parent or Guardian \_\_\_\_\_

Address \_\_\_\_\_

#### A. Medical History (May be completed by parent)

1. Does your child have any known allergies? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, what? \_\_\_\_\_

2. Is your 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 medical 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 authorized agent currently approved by the N.C. Board of Medical Examiners (or a comparable board from bordering states), a certified nurse practitioner, or 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: \_\_\_\_\_

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

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

Office Address  
(may use address stamp)