CHILDREN'S MEDICAL REPORT

Name of Child: _____
(Last) (First) (Middle) (Nickname)

Child's Date of Birth (mm/dd/yyyy): _____ /_____ / _____ **Child's Current Age:** _____

Name of Parent or Guardian: _____
(Last) (First) (Middle)

Address of Parent or Guardian: _____ **City:** _____ **State:** ___ **Zip Code:** _____

A. **Medical History** (May be Completed by Parent or Guardian)

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 child taking any continuous medication?** **No_____** **Yes_____** **If yes, what medication and for what purpose?** _____

4. **Any previous hospitalizations or operations?** **No_____** **Yes_____** **If yes, when and for what purpose/diagnosis?** _____
   _____

5. **Any history of significant previous diseases or recurrent illness?** **No_____** **Yes_____**
   Diabetes-No_____ Yes_____; Convulsions-No_____ Yes_____; Heart Trouble-No_____ Yes_____
   If others, please describe what and when _____
   _____

6. **Does 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)**

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(Last) (First) (Middle) (Nickname)

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Name of Parent or Guardian: _____
(Last) (First) (Middle)

Address of Parent or Guardian: _____ **City:** _____ **State:** ___ **Zip Code:** _____

B. Physical Examination:

This section and examination must be completed and signed by a licensed physician, his or 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** _____ **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: _____

Title of Examiner _____

Signature of Authorized Examiner _____ **Phone # ( ) _____-_____**

grace christian child development center

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