CHILDREN'S MEDICAL REPORT

Name of Child ______________________________ Date of Birth__________________
Name of Parent or Guardian ____
Address of Parent or Guardian ____

A. Medical History (May be completed by parent)

1. Is child currently under a doctor's care? No____Yes ___ If yes, for what reason?_____
____
2. Is the child on any continuous medication? No ___ Yes ___ If yes, what? _________
____
3. 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 ______
Please check those that apply. ___ Diabetes ___ Convulsions ___ Heart trouble _____
If others, what and when? ____
____
6. Does the child have any physical or 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.

Head__________Eyes _________Ears______________Nose____________Teeth _________
Throat __________Neck___________Heart_____________Chest___________GU________
Ext. ____________Neurological System______________________Skin _______________
Results of Tuberculin Test, if given: Type _____Date ________ Skin _______________
Should activities be limited? No _______ Yes ________ If yes, explain_____________
____
Any other recommendations ____
____

If the child has not received all vaccinations needed, please list those needed. _____
____

Signature of authorized examiner/title _____________________________________
Address ____
Phone #________________________________ Date: ___________________________

C. **Immunization History:** The health official must enter the date immunization was received in the space below or attach a copy of the immunization record.

Enter date of each dose – Month/Day/Year

Vaccine	#1	#2	#3	#4	#5
*DTP/Dt					
*Polio					
**Hib					
***HepB					
*MMR (combined doses)					
Measles (single dose)					
Mumps (single dose)					
Rubella (single dose)					
OTHER					

* Required by State law.
** Required by State law for children born on or after 10/1/91.
*** Required by State law for children born on or after 7/1/94.

Note: the State of North Carolina requires that a current immunization history be in your child's school file *no later* than 30 days following the start of the school year.