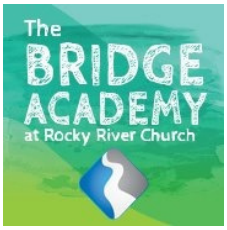

Children's Medical Report

Child's Name _____

Date of Birth _____ Male ( ) Female ( )

Name of Parent/Guardian_____

Address of
Parent/Guardian_____
Street #/Apt. # City State Zip Code

Home Phone _____ Cell Phone _____

Medical History (This section may be completed by a 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:

   _____
7. Any mental disabilities? No___ Yes___ If yes, please describe: _____

   _____

Signature of Parent/Guardian_____ **Date**_____

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704-795-7625 or 980-622-2088

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 ____ in. ____% Weight ____ lbs. ____%

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_____

Medical Practice Information

Practice Name _____

Address_____

Phone _____

Signature of Authorized

Examiner/Title_____