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A Five-Star Child Development Center

Children's Medical Report

Name of Child _____ Birth date _____
Name of Parent of Guardian _____
Address of Parent or Guardian _____

A. 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, 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 ____: Contagious/Communicable Disease No ____ Yes ____: If others, what/when? _____
   _____
6. Does the 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 _____

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. 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: _____

Insert "Office Address" In Box

Signature of authorized examiner/title _____

Date of Examination _____ Phone # _____

(May use address stamp)

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