REV. 8/92

Children's Medical Report

DPS 0369D
10 NCAC 3U .0801(3)
G.S. 110-91(1)

Name of Child_____Birthdate _____

Name of Parent or Guardian _____

Address of Parent of 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___.
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 practicioner, 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_____ 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)

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

G.S. 130A-155(b) requires all day care facilities to have this information on file.

Enter date of each dose - Month/Day/Year

VACCINE	#1	#2	#3	#4	#5
*DTP/DT					
*Polio					
**Hib					
*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.