



Children's Medical Report

Name of Child: _____ Birth Date: _____

Name of Parent or Guardian: _____

Address of Parent or Guardian: _____

A. Medical History (May be completed by parent)

1. Is child allergic to anything? Yes _____ No _____ If yes, what? _____

2. Is child currently under a doctor's care? Yes _____ No _____ If yes, for what reason? _____

3. Is the child on any continuous medication? Yes _____ No _____ If yes, what? _____

4. Any previous hospitalizations or operations? Yes _____ No _____ If yes, when and for what? _____

5. Any history of significant previous diseases or recurrent illness? Yes _____ No _____; diabetes Yes _____ No _____; convulsions Yes _____ No _____; heart trouble Yes _____ No _____. If others, what/when? _____

6. Does the child have any physical disabilities? Yes _____ No _____ If yes, please describe: _____

7. Does the child have any mental disabilities? Yes _____ No _____ 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/DU _____

Ext _____ Neurological System _____ Skin _____

Results of Tuberculin Test, if given: Type _____ Date _____ Normal _____ Abnormal _____

Should activities be limited? Yes _____ No _____ If yes, explain: _____

Any other recommendations: _____

Signature of authorized examiner: _____

Title of authorized examiner: _____

Date of Examination: _____

Phone: _____

Office Address
(may use address stamp)

Crossnore School, Inc. * Children's Medical Report * Page Two

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.

VACCINE	#1	#2	#3	#4	#5
*DTP/DT					
*Polio					*Required by State law **Required by State law for children born on or after 10/1/91
**Hib					
*MMR (combined doses)					
Measles (single doses)					
Mumps (single doses)					
Rubella (single doses)					
OTHER					