DCD 0108

12/99

Children's Medical Record

Name of Child _____Birthdate _____

Name of Parent or Guardian_____

Address of Parent or Guardian _____

A. Medical History (May be completed by the parent)

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

_____

2.Is child currently under doctor's care? No ____ Yes ___If yes, what reason?_____

3.Is the child on continuous medication? No ____ Yes ___If yes, what?_____

4.Any previous hospitalization or operations? No_ Yes _ If yes, when and what

for?_____

5.Any history of significant previous disease or recurrent illness? No___ Yes __ diabetes No___ Yes ___ ;

Convulsion No___ Yes ____; heart trouble No___ Yes ____ ; asthma No___ Yes ____ ; If others, what or 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: _____Date: _____

B. Physical Examination: This examination must be completed and signed by a licensed physician , his authorized agent currently approved by the N.C. Medical of Board Examiners (or a comparable board from bordering states), a certified nurse practitioner or a public health nurse meeting DHHS standards for EPSDT program.