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 ___________________________ Date ____________

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: __________________________________________________________ Date of Examination ______________

Signature of authorized examiner/title ___________________________ Phone # ____________