**Children’s Medical Report**

***This side to be completed by parent./Información diligenciada por los padres.***

Name of Child/Nombre del Niño(a):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate/Fecha de Nacimiento:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Parent or Guardian/Nombre del Padre o Tutor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone/Teléfono:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of Parent or Guardian/Dirección del Padre o Tutor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**A. Medical History/Historia Médica**

1. Is child allergic to anything?/¿El niño(a) tiene alergias? *yes/sí\_\_\_ no\_\_\_ If yes, what?/¿Cúal?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

2. Is child currently under a doctor’s care?/¿Está su niño(a) bajo cuidado médico? *yes/sí\_\_\_ no\_\_\_ If yes, for what reason?/Si lo está, ¿por qué*

*razón?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

3. Is the child on any continuous medication?/¿Está su niño(a) tomando medicamentos? *yes/sí\_\_\_ no\_\_\_ If yes, what?/Si está tomando*

*medicamentos, ¿Qué medicamentos?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

4. Any previous hospitalizations or operations?/¿El niño(a) ha estado hospitalizado o ha tenido alguna operación? *yes/sí\_\_\_ no\_\_\_ If yes,*

*when and for what?/Si marco “Sí”, ¿Cuándo y por qué?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

5. Any history of significant previous diseases or current illnesses?/¿El niño(a) ha enido o tiene actualmente alguna enfermedad

complicada? *yes/sí\_\_\_ no\_\_\_ diabetes\_\_\_ convulsions/convulsiones\_\_\_ heart trouble/enfermedades del corazón\_\_\_*

*If others, what/when?/Si tiene o ha tenido otras enfermedades, ¿Cuál/cuáles y cuándo?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

6. Does the child have any physical disabilities?/¿El niño(a) tiene alguna incapacidad fisica? *yes/sí\_\_\_ no\_\_\_ If yes, please describe/Si tiene*

*alguna incapacidad fisica, por favor describa:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

7. Does the child have any mental disabilities?/¿El niño(a) tiene alguna incapacidad mental? *yes/sí\_\_\_ no\_\_\_ If yes, please describe/Si tiene*

*alguna* *incapacidad mental, por favor describa:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**B. Development Evaluation/Evaluación de Desarrollo**

1. Has your child ever been evaluated for a possible development problem?/¿Su niño(a) ha sido evaludo/a por problemas en el desarollo?

*yes/sí\_\_\_ no\_\_\_ If yes, by what institution?/¿Si es así, ¿Cuál institución lo evaluó?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

3. Is your child currently receiving any kind of therapy?/¿Su niño(a) está recibiendo algún tipo de terapia en este momento? *yes/sí\_\_ no\_\_*

4. Do you feel your child needs an evaluation in any of these areas?/¿Su niño(a) necesita ser evaluado/a por problemas de?:

Language/Lenguaje *yes/sí*\_\_\_ *no\_\_\_* Hearing/Audición *yes/sí*\_\_\_  *no\_\_\_* Vision/Visión *yes/sí*\_\_\_  *no\_\_\_*

Motor Skills/Destrezas Motoras *yes/sí*\_\_\_  *no\_\_\_* Education/Educativos *yes/sí*\_\_\_  *no\_\_\_*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Signature of Parent or Guardian/Firma del Padre o Tutor Date/Fecha*

**Children’s Medical Report**

***This side to be completed by physician./Información diligenciada por el doctor.***

**C. 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.

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? Yes\_\_\_\_\_ No\_\_\_\_\_ If yes, explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other recommendations?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of authorized examiner/Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Date of Examination\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Office Address (may use stamp) |

***Medical office may substitute their copy of child’s immunization record.***

**Immunization History:** The 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 child care facilities to have this information on file.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Vaccine** | **#1** | **#2** | **#3** | **#4** | **#5** |
| \*DPT/DT |  |  |  |  |  |
| \*Polio |  |  |  |  |  |
| \*Hib |  |  |  |  |  |
| \*MMR (combined) |  |  |  |  |  |
| HepB |  |  |  |  |  |
| \*\*Varicella |  |  |  |  |  |
| Prevnar |  |  |  |  |  |

\*Required by State Law

\*\*Required for children born on or after 4/1/2001