Reporte Médico Infantil / Children's Medical Report

Name of Child _____ **Birthdate** _____
Nombre del Niño/a Fecha de Nacimiento

Name of Parent or Guardian _____
Nombre del Padre o Tutor Legal

Address of Parent or Guardian _____
Domicilio de Padre o Tutor Legal

Medical History (Parent fills out this portion)

Historial Médico (Padres puede llenar esta porción)

1. **¿Su niño/a es alérgico a algo?** ☐No ☐Si Si si, ¿A que es alérgico su niño/a? _____
   Is your child allergic to anything?
2. **¿Su niño/a está bajo el cuidado de algún medico?** ☐No ☐Si Si si, ¿por qué razón? _____
   Is child currently under a doctor's care?
3. **¿Está su niño bajo medicamento continuo?** ☐No ☐Si Si si, ¿qué medicamento está tomando?_____
   Is child on any continuous medication?
4. **¿Su niño ha tenido hospitalizaciones u operaciones?** ☐No ☐Si Si si, ¿cuándo y por qué motivo?_____
   Any previous hospitalizations or operations?
5. **¿Algun historial de enfermedades serias o recurrente?** ☐No ☐Si;
   ☐Diabetes ☐Convulsiones ☐Problemas del Corazon (heart trouble) ☐Asma (Asthma) ☐Otras:_____ (Others)
6. **¿Su niño/a tiene alguna discapacidad fisica?** ☐ No ☐Si Si si, describa:
   _____
   Does child have any physical disabilities?
7. **¿Su niño tiene alguna discapacidad mental?** ☐ No ☐Si Si si, describa:
   _____
   Does child have any mental disabilities?

Firma del Padre o Tutor Legal _____ **Fecha** _____

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 DHHS standards for EPSDT program.

Height _____% **Weight** _____%

Head_____ **Eyes**_____ **Ears**_____ **Nose**_____ **Teeth** _____ **Throat** _____
Neck_____ **Heart** _____ **Chest** _____ **Abd/GU** _____ **Ext** _____
Neurological System_____ **Skin**_____ **Vision**_____ **Hearing**_____
Results of Tuberculin Test, if given: Type _____ Date_____ ☐ Normal ☐Abnormal ☐Follow -up
Developmental Evaluation: ☐Delayed ☐ Age Appropriate
If delay, note significance and special care needed: _____
_____
Should activities be limited? No___ Yes___ If yes, explain:_____
Any other recommendations: _____
_____
_____

Date of Examination_____

Signature of authorized examiner/title _____ **Phone #**_____

DCD 0108
12/99

Children's Medical Report

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___; asthma 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 DHHS standards for EPSDT program.
Height _____% Weight _____%

Head_____ Eyes_____ Ears_____ Nose_____ Teeth_____Throat_____
Neck_____ Heart_____Chest_____Abd/GU_____Ext_____
Neurological System_____Skin_____Vision_____Hearing_____
Results of Tuberculin Test, if given: Type_____date_____ Normal___Abnormal_____followup_____

Developmental Evaluation: delayed_____age appropriate_____
If delay, note significance and special care needed;_____

_____

Should activities be limited? No___ Yes___ If yes, explain: _____
Any other recommendations:_____

_____

_____

Date of Examination_____

Signature of authorized examiner/title_____ **Phone #**_____