

**MEDICAL EXAMINATION FORM**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parents' Name: \_\_\_\_\_

Parents' Address: \_\_\_\_\_

**PART I: MEDICAL HISTORY**

(Family and child's history to be completed by parent/guardian before visit to examining physician)

**IMMEDIATE FAMILY HISTORY:** Any health problems in the child's parents or siblings, which are of concern in tracking the child's health: ( ) diabetes, ( ) stroke, ( ) epilepsy/seizures, ( ) kidneys, ( ) blood pressure, ( ) heart-attack under 60, ( ) birth defects, ( ) asthma, ( ) stomach/intestines, ( ) + TB skin test, ( ) deafness, ( ) anemia/blood disease, ( ) death at young age, ( ) substance abuse/name substance: \_\_\_\_\_, ( ) HIV; ( ) other \_\_\_\_\_.

Comments: \_\_\_\_\_

**CHILD'S HISTORY:** Epilepsy: \_\_\_\_\_, Rx Treatment: \_\_\_\_\_

Type and description of seizures: \_\_\_\_\_

Allergies/adverse reactions to medication, food, etc. \_\_\_\_\_

Diabetes: ( ) Yes ( ) No ( ) Unknown Alcohol/drug use: ( ) Yes ( ) No ( ) Unknown

Past hospitalizations (medical/psychiatric): \_\_\_\_\_

Surgery: \_\_\_\_\_

History of communicable disease (including STD): \_\_\_\_\_

History of chronic health problems: \_\_\_\_\_

History of birth control: ( ) Yes ( ) No ( ) Unknown Type: \_\_\_\_\_

Mental disorder or emotional illness: \_\_\_\_\_

Other: \_\_\_\_\_

**PART II: PHYSICIAN'S EXAMINATION OF CHILD AND RECOMMENDATIONS:**

**CHILD'S PHYSICAL EXAMINATION** (Check mark "✓" means normal):

Blood Pressure: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Vision: R 20/ \_\_\_\_\_ L 20/ \_\_\_\_\_

Head: \_\_\_\_\_ Eyes: \_\_\_\_\_ Ears: \_\_\_\_\_ Hearing: \_\_\_\_\_

Nose: \_\_\_\_\_ Mouth: \_\_\_\_\_ Teeth: \_\_\_\_\_ Throat: \_\_\_\_\_

Tonsils: \_\_\_\_\_ Heart: \_\_\_\_\_ Lungs: \_\_\_\_\_ Abdomen: \_\_\_\_\_

Hernia: \_\_\_\_\_ Genitals: \_\_\_\_\_ Extremities: \_\_\_\_\_

Positive findings of any medical/dental conditions needing attention: \_\_\_\_\_

Child's Name: \_\_\_\_\_

**TESTS:** (as indicated): BLOOD: Hct.: \_\_\_\_\_ HGB: \_\_\_\_\_ Other: \_\_\_\_\_  
Urine: Spec Gravity: \_\_\_\_\_ Sugar: \_\_\_\_\_ Protein: \_\_\_\_\_ Micro: \_\_\_\_\_

**COMMUNICABLE DISEASES:** Tests (as indicated): check tests administered and give results:

( ) VDRL Results: \_\_\_\_\_  
( ) HIV/AIDS Results: \_\_\_\_\_  
( ) HEPATITIS B Results: \_\_\_\_\_  
( ) Other ( ) Results: \_\_\_\_\_

Based on history and presenting condition, identify any additional tests for which this child should be considered:

\_\_\_\_\_

Has child had active TB in the past? ( ) Yes ( ) No Comments: \_\_\_\_\_

If "Yes", is treatment completed? ( ) Yes ( ) No Comments: \_\_\_\_\_

Has child had TB infection without active disease in the past? ( ) Yes ( ) No Comments: \_\_\_\_\_

If "Yes", is treatment completed? ( ) Yes ( ) No Comments: \_\_\_\_\_

If "No", and child is considered at risk, administer PPD; record date administered (\_\_\_\_/\_\_\_\_/\_\_\_\_) and results after 48 hours. Results: \_\_\_\_\_

Does the child have signs or symptoms of any communicable disease(s), which would pose a significant risk of transmission in a household setting? ( ) Yes ( ) No ( ) Unknown

If "Yes", Identify disease(s): \_\_\_\_\_

If "Yes", what treatment or restrictions are necessary for this individual and / or others in the household to prevent transmission: \_\_\_\_\_

**\*IMMUNIZATIONS:** Attached to this medical form must be a record of the child's immunizations, using the most recent version of NC Form DEHNR 1065 (NCARCCFS facsimile included in the forms list).

Has the child's immunization record been reviewed by the examining physician? ( ) Yes ( ) No

**RECOMMENDATIONS:**

Additional tests: \_\_\_\_\_

Follow-up treatment(s): \_\_\_\_\_

Medications: \_\_\_\_\_

Diet / Nutrition: \_\_\_\_\_

Limitations on physical activity: \_\_\_\_\_

Other: \_\_\_\_\_

**SIGNATURE** of Examining Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

(\* **Be sure to attach immunization record**