

# 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 \_\_\_ .  
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 # \_\_\_\_\_

## Carolina Pediatrics Universal Immunization Schedule

**Birth**- Hep B#1

**1 Month** - Hep B #2

**2 Month** – Pentacel, Prevnar, Rotateq -----#1  
(Pentacel- Dtap, IPV and Hib combination)

**4 Month** – Pentacel, Prevnar, Rotateq -----#2  
(Pentacel- Dtap, IPV and Hib combination)

**6 Month** – Pentacel, Prevnar, Rotateq -----#3  
(Pentacel- Dtap, IPV and Hib combination)

**9 Month** –Hep B -----#3

**12 Month** – MMR, Varivax, Hep A ----#1  
Prevnar -# 4

**15 Month** - DTaP #4, Hib #4

**18 Month or 21-22 Month** - Hep A #2

**4 or 5 Year** - MMR #2  
Varivax #2  
Dtap #5  
IPV #4

**11-12 Year** - TdaP  
Menactra  
Gardasil  
Varivax #2 if needed