

## HBUMP Children's Medical Report

Name of Child \_\_\_\_\_ Age \_\_\_\_\_ Birthday \_\_\_\_\_

Name of Parent/Guardian \_\_\_\_\_

Address \_\_\_\_\_

### A. MEDICAL HISTORY (Completed by parent/guardian)

1. Previous Hospitalization Yes \_\_\_ No \_\_\_ If so, why? \_\_\_\_\_

2. Is child allergic to anything Yes \_\_\_ No \_\_\_ If so, what? \_\_\_\_\_

3. Any ongoing or chronic illnesses Yes \_\_\_ No \_\_\_ If so, what? \_\_\_\_\_

4. Any physical handicaps Yes \_\_\_ No \_\_\_ If so, what? \_\_\_\_\_

5. Is child under care of doctor for something? Yes \_\_\_ No \_\_\_ If so, why? \_\_\_\_\_

6. Any history of diabetes \_\_\_\_\_ heart trouble \_\_\_\_\_ seizures \_\_\_\_\_ other \_\_\_\_\_

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### B. PHYSICAL EXAMINATION (Completed by physician) can be based on the last physical

Weight \_\_\_\_\_ Height \_\_\_\_\_ Heart \_\_\_\_\_ Chest \_\_\_\_\_ Throat \_\_\_\_\_ Neck \_\_\_\_\_ Abdomen \_\_\_\_\_ GU \_\_\_\_\_

Ext \_\_\_\_\_ Teeth \_\_\_\_\_ Skin \_\_\_\_\_ Head \_\_\_\_\_ Eyes \_\_\_\_\_ Ears \_\_\_\_\_ Tuberculin, if given \_\_\_\_\_

Should activities be limited? \_\_\_\_\_

Attach immunizations. Up-to-date on all required childhood immunizations? \_\_\_\_\_

Recommendations \_\_\_\_\_

\_\_\_\_\_

Physician Licensed by the NC Medical Board      Today's Date      Date of Exam (no more than one year ago)

Office Address \_\_\_\_\_ Telephone \_\_\_\_\_

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### C. IMMUNIZATION HISTORY (Can attach immunization record)

Vaccine	Date	Date	Date	Date	Date
DTP					
Polio					
HIB					
MMR					
Hep B					
Chicken Pox					
Other					

