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					