THOMAS R. BODENSTINE, M.D.
BRADLEY J. WASSERMAN, M.D.
TINA B. STEWART, M.D.
MARY-CASSIE SHAW, M.D.
ANGELICA SWIERSZ, M.D.

Oberlin Road Pediatrics

Children's Medical Report

Name of Child: _____ Birth date _____

Name of Parent or Guardian: _____

Address of Parent or Guardian: _____

A. Medical History (May be completed by parent)

1. Is child allergic to anything? No ___ Yes ___ If yes, for 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:

   _____

7. Does the child have any mental disabilities? No ___ Yes ___ If yes, please describe:

   _____

Signature of Parent or Guardian _____

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: _____

_____

Signature of authorized examiner / title _____

Date of Examination _____ Phone # _____

C. Immunization History:

The day care operator or health official must enter the date immunization was received in the space below of attach a copy of the immunization record. G.S.130A – 155(b) requires all day care facilities to have this information on file.

Enter date of each dose – Month / Day / Year

VACCINE	#1	#2	#3	#4	#5
DPT / DT (Circle which)					
Polio					
***Hib**					
MMR (combined doses)					
Measles (Single dose)					
Mumps (Single dose)					
Rubella (Single dose)					
Other					

*** Required by State Law**
**** Required by State Law for children born on or after 10 / 1 / 1991**