

Physical Examination

(To be completed and signed by a licensed physician, his/her authorized agent currently approved by the NC 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 _____ Skin _____

Neurological system _____

Should any activities be limited? No _____ Yes _____ If yes, please explain _____

Other recommendations _____

Signature and title of authorized examiner _____

Office address _____

Office phone _____ Date of examination _____

A copy of the child's current immunization record must be attached to this examination report. [G.S. 130A-155(b)]