



## PHYSICIAN'S REPORT

Child's Name: \_\_\_\_\_ Sex:  Male  Female Age: \_\_\_\_\_

**Objective Data:**

Height: \_\_\_\_\_ ( \_\_\_\_\_ %) Weight: \_\_\_\_\_ ( \_\_\_\_\_ %)

B.P.: \_\_\_\_\_ Pulse: \_\_\_\_\_

Vision	Date	Hearing	Date
Distance Acuity Right _____ Left _____		Pure Tone Testing (20 dB @ 1000, 2000, 4000 Hz)	
Tested with glasses? Yes _____ No _____		Right Ear: Pass _____ Fail _____	
Muscle Balance Pass _____ Fail _____ Not done _____		Left Ear: Pass _____ Fail _____	
Farsightedness: Pass _____ Fail _____ Not done _____		Other tests (specify) _____	
Color vision with pseudo		Child wears hearing aid? Yes _____ No _____	
Isochromic plates: Pass _____ Fail _____ Not done _____		Tested with hearing aid? Yes _____ No _____	
Child wears glasses? Yes _____ No _____		Referral made? Yes _____ No _____	
Glasses for: Distance _____ Reading _____ All Times _____			
Referral Made? Yes _____ No _____			

**Speech/Language**

Speech assessment: \_\_\_\_\_ done \_\_\_\_\_ not done \_\_\_\_\_ Child has no discernible speech problem

Child has possible problem with: \_\_\_\_\_ articulation \_\_\_\_\_ rhythm \_\_\_\_\_ voice \_\_\_\_\_ language

Speech evaluation recommended: \_\_\_\_\_ yes \_\_\_\_\_ no

**Laboratory Tests**

Hemoglobin/Hematocrit	Urine Protein	Urine Blood	Urine Glucose	Other

**Physical Examination**

Date examined: \_\_\_\_\_

\_\_\_\_\_ Essentially normal      Abnormalities as follows: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Is this child able to participate fully in the following:

Classroom and academic activities? _____ yes _____ no	Physical education classes? _____ yes _____ no
Competitive athletics? _____ yes _____ no	Contact sports? _____ yes _____ no

If limitations are recommended, please specify: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Does this child have any special needs that the school/school nurse can assist with special programs or attention? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Medications**

What medications is this child currently taking? Please list below.	
Medication	Reason for taking

**Immunizations** Required by Law to attend school

DPT \_\_\_\_\_

Polio \_\_\_\_\_

MMR \_\_\_\_\_

Hepatitis B \_\_\_\_\_

Varicella (chickenpox) \_\_\_\_\_ (effective Fall 2006 for Kindergarten)

HIB \_\_\_\_\_ (Daycare, Head Start, and Pre-School only)

TB Test \_\_\_\_\_ Result: Neg \_\_\_\_\_ or Pos \_\_\_\_\_

Other \_\_\_\_\_

**Please Print or Stamp:**

Physician's Name	Signature
Address	Date Signed
Phone	