

# Physician's Report

Child's Name	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Date
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## Objective Data

Height _____ ( _____ %)	Weight _____ ( _____ %)	B.P. _____ / _____
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## Screening Test

Vision	Date	Hearing	Date
Distance Acuity      right _____      left _____		Pure tone testing:	
Muscle Balance <input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> not done		Right ear <input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> not done	
Farsightedness <input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> not done		Left ear <input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> not done	
Color <input type="checkbox"/> pass <input type="checkbox"/> fail <input type="checkbox"/> not done		Other tests (specify) _____	
Child wears glasses? <input type="checkbox"/> yes <input type="checkbox"/> no		Child wears hearing aid? <input type="checkbox"/> yes <input type="checkbox"/> no	
Tested with glasses? <input type="checkbox"/> yes <input type="checkbox"/> no		Tested with hearing aid? <input type="checkbox"/> yes <input type="checkbox"/> no	
Referral made? <input type="checkbox"/> yes <input type="checkbox"/> no		Referral made? <input type="checkbox"/> yes <input type="checkbox"/> no	

## Speech/Language

Speech assessment: <input type="checkbox"/> done <input type="checkbox"/> not done <input type="checkbox"/> Child has no discernible speech problem
Child has possible problem with: <input type="checkbox"/> Articulation <input type="checkbox"/> Rhythm <input type="checkbox"/> Voice <input type="checkbox"/> Language
Speech evaluation recommended: <input type="checkbox"/> yes <input type="checkbox"/> no

## Laboratory Test

<input type="checkbox"/> Hematocrit/Hemoglobin <input type="checkbox"/> Urine protein <input type="checkbox"/> Urine blood <input type="checkbox"/> Urine glucose <input type="checkbox"/> Other:
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## Physical Examination:

Date examined: _____
<input type="checkbox"/> Essentially normal      Abnormalities as follows: _____ _____
Is this child able to participate fully in the following:
A. Classroom and academic activities? <input type="checkbox"/> yes <input type="checkbox"/> no      C. Competition athletics? <input type="checkbox"/> yes <input type="checkbox"/> no
B. Physical education classes? <input type="checkbox"/> yes <input type="checkbox"/> no      D. Contact and collision sports? <input type="checkbox"/> yes <input type="checkbox"/> no
If limitations are advised, please specify those limitations: _____ _____
If this child has any physical, developmental or behavioral problems, how can the school assist with special programs, placement or attention? _____ _____

## Physician's Assessment

Problem list	Recommendation for school management
1.	1.
2.	2.
3.	3.

## Please print or stamp

Physician's Name	Physician's Signature
Address	Date Signed
Phone	

## Immunizations given this visit: