Physician's Report

Child's Name	Sex € Male Female	Age	Date

Objective Data

Height	Weight	B.P.
(%)	(%)	/

Screening Test

Vision			Date	Hearing			Date
Distance Acuity	right____________		left _______________	Pure tone testing:			
Muscle Balance	€ pass	€ fail	€ not done	Right ear	€ pass	€ fail	€ not done
Farsightedness	€ pass	€ fail	€ not done	Left ear	€ pass	€ fail	€ not done
Color	€ pass	€ fail	€ not done	Other tests (specify)____			
Child wears glasses?	€ yes	€ no		____			
Tested with glasses?	€ yes	€ no		Child wears hearing aid?	€ yes	€ no	
Referral made?	€ yes	€ no		Tested with hearing aid?	€ yes	€ no	
				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 Test

€ Hematocrit/Hemoglobin € 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:

A. Classroom and academic activities? € yes € no C. Competition athletics? € yes € no

B. Physical education classes? € yes € no D. Contact and collision sports? € yes € 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: