

Name _____ Sex: M ___ F ___ Birth Date: _____

Address _____ School _____

To the Physician: Please complete both sides and return to the child's school in attached envelope.

BIRTH HISTORY: (Optional)

Pre-natal Complications _____

Birth Weight _____ Delivery _____

Neo-natal Complications _____

DEVELOPMENTAL MILESTONES:

Sat _____ mo. Crawl _____ mo. Walked _____ mo.

Words _____ mo. Sentences _____ mo.

Toilet Trained _____ mo.

MEDICAL HISTORY:

Serious Illnesses or injuries _____

Surgery _____

Allergic Reactions _____

IMMUNIZATIONS OF (NUMBER DOSES AND DATES):

DPT 1 2 3 4 5

or TD 1 2 3 4 5

Polio 1 2 3 4 5

Measles _____

Mumps _____

Rubella _____

H.I.B. _____

Hepatitis B _____ (over)

Other _____

(N= Normal, O= Over for Comment.)		Under RX
Date of Examination		
Wt. _____	Ht. _____	
Eyes _____	Vision R:20/ _____ L:20/ _____	
Ears _____	Hearing _____	
Nose _____		
Mouth _____	Speech _____	
Throat _____	Tonsils _____	
Teeth _____	Orthodontia Needed _____	
Heart _____	B.P. _____	
Lungs _____		
Abdomen _____	Hernia _____	
G-U _____		
Nervous System _____		
Skin _____		
Posture _____		

(Please indicate deviations from normal)

Other Orthopedic _____

Blood _____ Urine _____

Mantoux Test: Given _____ Read _____

Pos. _____ (date) (date)

(Indur. mm) Chest X-ray _____ Results: _____

Neg. _____ (date)

EXAMINATION BY PRIVATE PHYSICIAN (continued)

Currently does this child need help with:

Motor Development _____

Speech _____

Behavior _____

Emotional Growth _____

Has this child had:

Psychological Testing _____

Neurological Referral _____

Psychiatric Referral _____

Other Counseling _____

Current Medication: No _____ Yes _____ What _____

PARENTAL REQUEST: I request that my physician release this completed report to the school.

Parent/Guardian Signature _____ Date _____

PLEASE Return To:

School _____

Address _____

City _____ Zip _____

Recommendations and Comments:

(Physical Education required by State Law):

Reg. _____

Limited or Adaptive _____ Why _____

Signature _____ M.D.

_____ M.D.

(Please type or print name)

Address _____

Phone _____ Date _____