PHYSICIAN'S SUMMARY REPORT

Student:_____ Date of birth: _____

Diagnosis/Medical History (including allergies):_____

_____

Height: _____ Weight: _____ BP: _____ Pulse: _____ Resp: _____

Visual Acuity (rt)_____ (lt)_____ Hearing Acuity (rt)_____ (lt)_____

Glasses? yes no Aides? yes no

EXAMINATION			
Head		Respiratory	
Ears		GU	
Nose		Fine/Gross Motor	
Throat		Scoliosis	
Cardiovascular		Metabolic/Endocrine	
GI		Skin	
Adaptive Devices			
If Down Syndrome: Atlantoaxial subluxation?			Date of X-ray:
Serious illness/injury in past 3 years: (specify with date)			

RESTRICTIONS: Medical/Gym/Swimming/Recommendations pertaining to educational program or school management? (specify)

MEDICATION	**Total Dosage**	**Dosage Administered During School Hours**

IMMUNIZATION HISTORY **Required Immunizations**	**Dates of First Series:** **1st**	**2nd**	**3rd**	**Dates of Boosters:** **1st**	**2nd**
Td					
DPT					
Polio (oral or injection)					
MMR					
HIB					
Hepatitis B					
Optional Tests	**Date**	**Results**	Date of Chicken Pox Vaccine		
Lead			**Comments/Other:**		
Sickle Cell					
Tuberculin					

Do you recommend inclusion of this child in a group educational setting? Yes ☐ No ☐

Date of Examination: _____ Name of Physician:_____

Physician Phone No.: _____ Physician Address: _____

Signature of Person Completing Form: _____

Title: _____Date: _____